WMI MUTUAL INSURANCE COMPANY
SCHEDULE OF BENEFITS SUMMARY
Idaho Silver 1 Plan
HIOS PLAN ID 72114ID0060002-00

Eligible services and treatments are covered at the benefit levels shown below, and are subject to all other terms, limitations, and exclusions as set forth in the Policy.

	PPO PROVIDERS	NON-PPO PROVIDERS
This plan covers Essential Benefits. "Essential Benefits" means: 1) Ambulatory patient services; 2) Emergency services; 3) Hospitalization; 4) Maternity and newborn care; 5) Mental health and substance abuse, including behavioral health treatment; 6) Prescription drugs; 7) Rehabilitative and habilitative services and devices; 8) Laboratory services; 9) Preventive and wellness services and chronic disease management; and 10) Pediatric services, including oral and vision care. There are no annual or lifetime dollar limits applicable to essential benefits. Any benefit-specific dollar limits referenced in the Schedule of Benefits pertain only to those health care services and supplies that are not essential benefits.		
DEDUCTIBLE PER CALENDAR YEAR: Deductible does not apply to PPO preventive and wellness services or to Generic Prescription Drugs.		
Per Individual	$1,500 for medical services $250 for Prescription Drugs	
Per Family	$3,000 for medical services $500 for Prescription Drugs	
MAXIMUM OUT-OF-POCKET AMOUNT PER CALENDAR YEAR: Amounts paid for non-covered care or treatment and for balance-billed amounts from non-ppo providers do not apply towards the Out-of-Pocket amounts. **Be aware that your actual costs for services provided by non-ppo providers may exceed the maximum out-of-pocket amount. Non-ppo providers can bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company, and that amount is not counted toward the out-of-pocket maximum.**		
Per Individual	$4,200 for medical and Prescription Drug services	
Per Family	$8,400 for medical and Prescription Drug services	
The Plan will pay the designated coinsurance percentage of Covered Services until Out-of-Pocket amounts are reached, at which time the Plan will pay 100% of Covered Services during the Calendar Year.		
COVERED SERVICES	**PPO PROVIDERS (coinsurance amount paid by the Plan)**	**NON-PPO PROVIDERS (coinsurance amount paid by the Plan)**
Note: Any visit maximums listed below are the total for PPO and Non-PPO expenses combined. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between PPO and Non-PPO providers		
Hospital Services		
• **Room and Board**	60% after Deductible, of the	45% after Deductible, of the

	facility's semi-private room rate	facility's semi-private room rate
• **Intensive Care**	60% after Deductible, of the hospital's ICU charge	45% after Deductible, of the hospital's ICU charge
• **Skilled Nursing Facility**	60% after Deductible, of the facility's semi-private room rate, limited to 30 days per Calendar Year	45% after Deductible, of the facility's semi-private room rate, limited to 30 days per Calendar Year
Outpatient hospital and ambulatory patient services	60% after Deductible	45% after Deductible
Emergency Department Services	60% after Deductible	60% after Deductible, if services are for an Emergency* as defined below, otherwise, 45% after Deductible
***Emergency** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.		
Physician Services		
• **Inpatient Visits**	60% after Deductible	45% after Deductible
• **Office Visits/Specialist Visits**	60% after Deductible	45% after Deductible
• **Surgery**	60% after Deductible	45% after Deductible
Home Health Care	60% after Deductible	45% after Deductible
Laboratory tests, diagnostic x-rays, ultrasounds	60% after Deductible	45% after Deductible
Imaging (MRI, CAT/PET scans)	60% after Deductible	45% after Deductible
Hospice Care	60% after Deductible	45% after Deductible
Ambulance Service	60% after Deductible	45% after Deductible
Jaw Joint/TMJ (Limited to medically necessary surgery)	60% after Deductible	45% after Deductible
Physical Therapy, Occupational Therapy and Speech Therapy for Rehabilitative purposes	60% after Deductible, limited to 20 visits per Calendar Year on a combined basis	45% after Deductible, limited to 20 visits per Calendar Year on a combined basis
Physical Therapy, Occupational Therapy and Speech Therapy for Habilitative purposes	50% after Deductible, limited to 20 visits per Calendar Year on a combined basis	40% after Deductible, limited to 20 visits per Calendar Year on a combined basis
Other Habilitative Services	60% after Deductible	45% after Deductible
Durable Medical Equipment (Limited to no more than purchase price)	60% after Deductible	45% after Deductible
Prosthetics	60% after Deductible	45% after Deductible
Orthotics	60% after Deductible	45% after Deductible
Spinal Manipulation and Modalities	60% after Deductible	45% after Deductible

Mental Illness Treatment		
• **Inpatient**	60% after Deductible	45% after Deductible
• **Outpatient**	60% after Deductible	45% after Deductible
Chemical Dependency Treatment		
• **Inpatient**	60% after Deductible	45% after Deductible
• **Outpatient**	60% after Deductible	45% after Deductible
Organ Transplants and Joint Implants (refer to Plan for specific types)	60% after Deductible	45% after Deductible
Maternity Services	60% after Deductible	45% after Deductible
Circumcisions (must be performed within 30 days of birth)	60% after Deductible, limited to $150	45% after Deductible, limited to $150
Sleep studies	60% after Deductible	45% after Deductible
Sleep apnea treatment	60% after Deductible	45% after Deductible
Preventive Care		
• **U.S. Preventive Services Task Force screening and tests with a rating of A or B**	100% (not subject to Deductible)	45% after Deductible
• **Routine immunizations for children, adolescents and adults**[1]	100% (not subject to Deductible)	45% after Deductible
[1]Subject to the guidelines as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control		
• **U.S. Health Resources and Services Administration screening and tests for infants, children, adolescents and women**	100% (not subject to Deductible)	45% after Deductible
• **Routine physical examinations and check-ups, including well baby/child visits**[2]	100% (not subject to Deductible)	45% after Deductible
[2]Includes office visits, influenza immunizations, gynecological exams, and lab tests required for the examination		
• **Prostate cancer screening**	100% (not subject to Deductible)	45% after Deductible
• **Colorectal cancer screening**[3]	100% (not subject to Deductible)	45% after Deductible
[3]Beginning at age 50 and subject to the U.S. Preventive Services Task Force and Centers for Disease Control and Prevention guidelines.		
• **Mammography**[4]	100% (not subject to Deductible)	45% after Deductible
[4]Frequency limits for mammogram: A baseline mammogram for any woman who is thirty-five (35) through thirty-nine (39) years of age. A mammogram every two (2) years for any woman who is forty		

(40) through forty-nine (49) years of age, or more frequently if recommended by the Insured's Physician or Practitioner. A mammogram every year for any woman who is fifty (50) years of age or older.		
Other General Covered Services and Supplies (as set forth in the Plan)	60% after Deductible	45% after Deductible
Pediatric Vision (coverage is only available for Children through the age of 18)		
• **Vision screening**	60% after Deductible; limited to one test per Calendar Year	45% after Deductible; limited to one test per Calendar Year
• **Prescription lenses**	60% after Deductible; limited to one pair per Calendar Year	45% after Deductible; limited to one pair per Calendar Year
• **Frames**	60% after Deductible; limited to one pair per Calendar Year	45% after Deductible; limited to one pair per Calendar Year
• **Contacts**	60% after Deductible; limited to once per Calendar Year in lieu of lenses and frames	45% after Deductible; limited to once per Calendar Year in lieu of lenses and frames
	Coinsurance amount paid by the Plan	
Pediatric Dental (coverage is only available for Children through the age of 18)		
• **Diagnostic and Preventive Services**	60% after Deductible	
• **Restorative, Endodontic and Periodontic Services**	60% after Deductible	
• **Prosthodontic Services**	60% after Deductible	
• **Orthodontic Services** (orthodontic treatment for cosmetic purposes is not covered)	60% after Deductible	
• **General Services**	60% after Deductible	
	Coinsurance amount paid by the Plan	
Prescription Drugs – coverage is subject to all Policy guidelines. A Generic drug must be used whenever a Generic equivalent is available. If a Brand drug is purchased instead of a Generic equivalent, the Insured is responsible for the price difference.		
• Generic Drugs	70% (not subject to Deductible)	
• Brand Drugs	50% after Deductible	
• Specialty Drugs	50% after Deductible	