WMI MUTUAL INSURANCE COMPANY
SCHEDULE OF BENEFITS SUMMARY
Nevada Gold 2 Plan

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 Health Benefits (EHB). "Essential Health Benefits" means the set of benefits within the Nevada EHB benchmark plan. 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, to primary care visits, to specialist visits, to laboratory services, to x-rays, to preventive pediatric dental services, or to Generic Prescription Drugs.		
Per Individual	$1,000 for medical services $250 for Prescription Drugs	
Per Family	$2,000 for medical services $500 for Prescription Drugs	
MAXIMUM OUT-OF-POCKET AMOUNT PER CALENDAR YEAR: Amounts paid for non-covered care or treatment do not apply towards the Out-of-Pocket amounts.		
Per Individual	$3,400 for medical and Prescription Drug services	
Per Family	$6,800 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: Services may be obtained from a PPO provider or a non-PPO provider. Eligible benefits for a PPO provider will be processed according to a discounted rate and will be reimbursed at a higher percentage level. Eligible benefits for a non-PPO provider will be processed according to the usual and customary allowable amount and will be reimbursed at a lower percentage level. Any billed amount above the usual and customary allowance will be the responsibility of the insured individual.		
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**	70% after Deductible, of the facility's semi-private room rate	55% after Deductible, of the facility's semi-private room rate
• **Intensive Care**	70% after Deductible, of the hospital's ICU charge	55% after Deductible, of the hospital's ICU charge
• **Skilled Nursing Facility**	70% after Deductible, of the facility's semi-private room rate,	55% after Deductible, of the facility's semi-private room rate,

	limited to 100 days per Calendar Year	limited to 100 days per Calendar Year
Outpatient hospital and ambulatory patient services	70% after Deductible	55% after Deductible
Emergency Department Services	70% after Deductible	70% after Deductible, if services are for an Emergency* as defined below, otherwise, 55% after Deductible
***Emergency** means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, and that failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.		
Physician Services		
• **Inpatient Visits**	70% after Deductible	55% after Deductible
• **Office Visits/Specialist Visits**	70% (not subject to Deductible)	55% (not subject to Deductible)
• **Surgery**	70% after Deductible	55% after Deductible
Home Health Care	70% after Deductible, limited to 30 visits per Calendar Year	55% after Deductible, limited to 30 visits per Calendar Year
Laboratory tests, diagnostic x-rays, ultrasounds	70% (not subject to Deductible)	55% (not subject to Deductible)
Imaging (MRI, CAT/PET scans)	70% after Deductible	55% after Deductible
Hospice Care	70% after Deductible	55% after Deductible
Ambulance Service	70% after Deductible	55% after Deductible
Jaw Joint/TMJ	70% after Deductible	55% after Deductible
Physical Therapy, Occupational Therapy and Speech Therapy for Rehabilitative purposes	50% after Deductible, limited to 60 visits per Calendar Year on a combined basis	40% after Deductible, limited to 60 visits per Calendar Year on a combined basis
Physical Therapy, Occupational Therapy and Speech Therapy for Habilitative purposes	70% after Deductible, limited to 60 visits per Calendar Year on a combined basis	55% after Deductible, limited to 60 visits per Calendar Year on a combined basis
Other Habilitative Services (including applied benefit analysis for autism spectrum disorders)	70% after Deductible	55% after Deductible
Durable Medical Equipment (Limited to no more than purchase price)	70% after Deductible	55% after Deductible
Prosthetics	70% after Deductible	55% after Deductible
Orthotics	70% after Deductible	55% after Deductible
Spinal Manipulation and Modalities	70% after Deductible	55% after Deductible
Mental Illness Treatment		
• **Inpatient**	70% after Deductible	55% after Deductible

• **Outpatient**	70% after Deductible	55% after Deductible
Treatment for Alcohol/Substance Abuse Disorder		
• **Inpatient**	70% after Deductible	55% after Deductible
• **Outpatient**	70% after Deductible	55% after Deductible
Organ Transplants and Joint Implants (refer to Plan for specific types)	70% after Deductible	55% after Deductible
Maternity Services	70% after Deductible	55% after Deductible
Circumcisions (must be performed within 30 days of birth)	70% after Deductible, limited to $150	55% after Deductible, limited to $150
Sleep studies	70% after Deductible, limited to $2,500 per Calendar Year	55% after Deductible, limited to $2,500 per Calendar Year
Sleep apnea treatment	70% after Deductible; treatments that are not Essential Benefits are limited to $5,000 per Calendar Year	55% after Deductible; treatments that are not Essential Benefits are limited to $5,000 per Calendar Year
Preventive Care (you may also refer to the following website: http://doi.nv.gov/Healthcare-Reform/Individuals-Families/Preventative-Care/)		
• **U.S. Preventive Services Task Force screening and tests with a rating of A or B**	100% (not subject to Deductible)	55% after Deductible
• **Routine immunizations for children, adolescents and adults**[1]	100% (not subject to Deductible)	55% 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)	55% after Deductible
• **Routine physical examinations and check-ups, including well baby/child visits**[2]	100% (not subject to Deductible)	55% 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)	55% after Deductible
• **Colorectal cancer screening**[3]	100% (not subject to Deductible)	55% 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)	55% after Deductible
[4]Frequency limits for mammogram: Baseline for women ages 35-40; annually for women 40 years of age or older		
Other General Covered Services and Supplies (as set forth in the Plan)	70% after Deductible	55% after Deductible
Pediatric Vision (coverage is only available for Children through the age of 18)		
• **Vision screening**	70% after Deductible; limited to one test per Calendar Year	55% after Deductible; limited to one test per Calendar Year
• **Prescription lenses**	70% after Deductible; limited to one pair per Calendar Year	55% after Deductible; limited to one pair per Calendar Year
• **Frames**	70% after Deductible; limited to one pair per Calendar Year	55% after Deductible; limited to one pair per Calendar Year
• **Contacts**	70% after Deductible; limited to once per Calendar Year in lieu of lenses and frames	55% 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**	70% after Deductible*	
• **Restorative, Endodontic and Periodontic Services**	70% after Deductible	
• **Prosthodontic Services**	70% after Deductible	
• **Orthodontic Services** (orthodontic treatment for cosmetic purposes is not covered)	70% after Deductible	
• **General Services**	70% after Deductible	
***Periodic and comprehensive oral examinations, prophylaxis, and bitewing x-rays are not subject to the Deductible.		
	Coinsurance amount paid by the Plan	
Orally Administered Chemotherapy - coverage is subject to all Policy guidelines. This Benefit is separate from the Prescription Drug Benefit.		
• Generic Drugs	100%, after a $25 co-payment*	
• Brand Drugs	100%, after a $100 co-payment*	
*The co-payment amount does not apply after the maximum Out-of-Pocket amount has been satisfied.		
	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	75% (not subject to Deductible)	
• Brand Drugs	50% after Deductible	
• Specialty Drugs	50% after Deductible	