WMI MUTUAL INSURANCE COMPANY
SCHEDULE OF BENEFITS SUMMARY
Arizona 150 80/60 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.

"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, provided the services are otherwise eligible according to the terms of the policy. 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 routine physical examinations and check-ups, to medical foods for inherited metabolic disorders, to amino acid-based formulas for eosinophilic disorder, or to Generic Prescription Drugs.		
Per Individual	\$150 for medical services \$50 for Prescription Drugs	
Per Family	\$450 for medical services No family maximum for Prescription Drugs	
MAXIMUM OUT-OF-POCKET AMOUNT PER CALENDAR YEAR: Amounts paid for mental health treatment, for alcohol/substance abuse treatment, for jaw joint/TMJ surgery, for Prescription Drugs (except for patient-administered cancer treatment medications) and for non-covered care or treatment do not apply towards the Out-of-Pocket amounts.		
Per Individual	\$2,000 for medical	
Per Family	\$4,000 for medical	
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**	80% after Deductible, of the facility's semi-private room rate	60% after Deductible, of the facility's semi-private room rate
• **Intensive Care**	80% after Deductible, of the hospital's ICU charge	60% after Deductible, of the hospital's ICU charge
• **Extended Care/Rehabilitation**	80% after Deductible, of the facility's semi-private room rate,	60% after Deductible, of the facility's semi-private room rate,

Care Facility	limited to 60 days per Calendar Year	limited to 60 days per Calendar Year
Outpatient hospital and ambulatory patient services	80% after Deductible	60% after Deductible
Emergency Department Services	80% after Deductible	60% after Deductible
Physician Services		
• **Inpatient Visits**	80% after Deductible	60% after Deductible
• **Office Visits/Specialist Visits**	80% after Deductible	60% after Deductible
• **Surgery**	80% after Deductible	60% after Deductible
Home Health Care	80% after Deductible	60% after Deductible
Laboratory tests, diagnostic x-rays, ultrasounds	80% after Deductible	60% after Deductible
Imaging (MRI, CAT/PET scan)	80% after Deductible	60% after Deductible
Hospice Care	80% after Deductible	60% after Deductible
Ambulance Service	80% after Deductible	60% after Deductible
Jaw Joint/TMJ (Limited to medically necessary surgery)	50% after Deductible	50% after Deductible
Physical Therapy	80% after Deductible	60% after Deductible
Durable Medical Equipment (Limited to no more than purchase price)	80% after Deductible	80% after Deductible
Prosthetics	80% after Deductible	80% after Deductible
Spinal Manipulation and Modalities	80% after Deductible	60% after Deductible
Mental Illness Treatment		
• **Inpatient**	60% after Deductible, limited to a maximum of 15 days per Calendar Year	50% after Deductible, limited to a maximum of 15 days per Calendar Year
• **Outpatient**	60% after Deductible, limited to a maximum of 20 visits per Calendar Year	50% after Deductible, limited to a maximum of 20 visits per Calendar Year
Alcohol/Substance Abuse Treatment		
• **Inpatient**	50% after Deductible	50% after Deductible
• **Outpatient**	50% after Deductible	50% after Deductible
Organ Transplants and Joint Implants (refer to Plan for specific types)	80% after Deductible	60% after Deductible
Maternity Services	80% after Deductible	60% after Deductible
Circumcisions (must be performed within 30 days of birth)	80% after Deductible, limited to $150	60% after Deductible, limited to $150
Sleep studies	80% after Deductible, limited to $1,000 per Calendar Year	60% after Deductible, limited to $1,000 per Calendar Year
Sleep apnea treatment	80% after Deductible; treatments that are not Essential	60% after Deductible; treatments that are not Essential

	Benefits are limited to $5,000 per Calendar Year	Benefits are limited to $5,000 per Calendar Year
Colonoscopy screening*	80% after Deductible	60% after Deductible
*Subject to the following guidelines: Once every 10 years beginning at age 50. Once every 5 years beginning at age 40 if colorectal cancer or adenomatous polyps were present in any first-degree relative (parent, sibling, or child) before the relative's age of 60, or in two or more first-degree relatives at any age. Follow-up colonoscopies as frequently as is determined to be medically necessary due to the presence of colorectal cancer or adenomatous polyps.		
Mammography*	80% after Deductible	60% after Deductible
*Subject to the following guidelines and to all other provisions of the policy: Preventive mammography screening and diagnostic imaging performed on dedicated equipment for diagnostic purposes on referral by a patient's physician. Coverage includes digital breast tomosynthesis, magnetic resonance imaging, ultrasound or other modality and at such age and intervals as recommended by the National Comprehensive Cancer Network. This includes patients at risk for breast cancer who have a family history with one or more first or second degree relatives with breast cancer, prior diagnosis of breast cancer, positive testing for hereditary gene mutations or heterogeneously or dense breast tissue based on the breast imaging reporting and data system of the American College of Radiology.		
Routine Physical Examinations and Check-ups		
• **Well Baby/Child Examinations** (for children up to and including age 18)*	80% (not subject to Deductible)	60% (not subject to Deductible)
*Frequency limits are subject to the guidelines of the American Academy of Pediatrics		
• **Routine physical examination** (for age 19 or older)*	80% (not subject to Deductible)	60% (not subject to Deductible)
*This benefit includes the examination and routine lab procedures required for the examination, including, but not limited to, routine adult immunizations, gynecological exams and prostate tests. This benefit does not include mammograms or colonoscopies, which are covered elsewhere in the Policy.		
• **Routine childhood immunizations and influenza immunizations**	80% (not subject to Deductible)	80% (not subject to Deductible)
Supplemental accident benefit	100%, not subject to Deductible, to a maximum of $300, thereafter, at regular benefits	100%, not subject to Deductible, to a maximum of $300, thereafter, at regular benefits
Other General Covered Services and Supplies (as set forth in the Plan) (with the exception of medical foods and amino-acid based formulas)	80% after Deductible	60% after Deductible
Medical foods for inherited metabolic disorder	50% (not subject to Deductible)	50% (not subject to Deductible)
Amino-acid based formula for eosinophilic disorder	75% (not subject to Deductible)	75% (not subject to Deductible)
	Coinsurance amount paid by the Insured	
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. Prescription Drugs that are not purchased through the Prescription Drug card plan will be paid in accordance with the Prescription Drug card plan benefit and not as major medical benefits. They will also be limited to the maximum allowable cost, less any available discounts, that would have been available had the drugs been purchased through the Prescription Drug card plan.

An Insured's contribution to any coinsurance, deductible or out-of-pocket amount shall include any cost sharing amounts paid by either the Insured or another person on behalf of the Insured for a prescription drug that is either: 1) without a generic equivalent; or 2) with a generic equivalent where the Insured obtained access to the prescription drug through any of the following: a) prior authorization; or b) the exception and appeals process of the insurer.

• Generic Drugs	20% or $10, whichever is greater (not subject to Deductible)*
• Brand Drugs	30% or $30, whichever is greater (after Deductible)*

*The coinsurance amount paid by the Insured for patient-administered cancer treatment medications, including medications that are orally-administered or self-injected, will be 20%, (not subject to Deductible) for generic drugs and 20% (after Deductible) for brand drugs. Copayment amounts do not apply to those types of medications.