The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call us at 1-800-748-5340 or visit us at www.wmimutual.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-748-5340 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$3,500** person/ **$7,000** family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preferred provider preventive care and preventive pediatric dental are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$6,000** person/**$12,000** family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on the plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges (unless balance billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.azfmc.com or call 1-800-748-5340 for a list of preferred providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

* For more information about limitations and exceptions, see the plan or policy document at www.wmimutual.com.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	40% coinsurance	55% coinsurance	None
	Specialist visit	40% coinsurance	55% coinsurance	None
	Preventive care/screening/ immunization	0% coinsurance	55% coinsurance	Deductible does not apply to preferred provider preventive care.
If you have a test	Diagnostic test (x-ray, blood work)	40% coinsurance	55% coinsurance	None
	Imaging (CT/PET scans, MRIs)	40% coinsurance	55% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at 1-800-748-5340.	Generic drugs	25% coinsurance	25% coinsurance	If a generic drug is available, the plan pays equal to the generic amount and the patient pays the difference. Self-injectable drugs are paid under the prescription drug benefit even if they are administered by a provider. For patient-administered cancer treatment medications, including medications that are orally-administered or self-injected, coinsurance is 20% after deductible.
	Brand drugs	50% coinsurance	50% coinsurance	
	Specialty drugs	50% coinsurance	50% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	55% coinsurance	None
	Physician/surgeon fees	40% coinsurance	55% coinsurance	None
If you need immediate medical attention	Emergency room care	40% coinsurance	55% coinsurance	Non-preferred provider services will be paid at the preferred provider coinsurance if services are for a life-threatening condition.
	Emergency medical transportation	40% coinsurance	55% coinsurance	None
	Urgent care	40% coinsurance	55% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	55% coinsurance	A 10% penalty applies for non-emergency admissions that are not pre-certified. *See

* For more information about limitations and exceptions, see the plan or policy document at www.wmimutual.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
				section IV, A of the policy.
	Physician/surgeon fees	40% coinsurance	55% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	40% coinsurance	55% coinsurance	None
	Mental/Behavioral health inpatient services	40% coinsurance	55% coinsurance	None
	Substance abuse inpatient services	40% coinsurance	55% coinsurance	None
	Substance abuse outpatient services	40% coinsurance	55% coinsurance	None
If you are pregnant	Office visits	40% coinsurance	55% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	40% coinsurance	55% coinsurance	
	Childbirth/delivery facility services	40% coinsurance	55% coinsurance	
If you need help recovering or have other special health needs	Home health care	40% coinsurance	55% coinsurance	None
	Rehabilitation services	40% coinsurance	55% coinsurance	Physical therapy, occupational therapy and speech therapy for rehabilitative purposes are limited to 60 visits per Calendar Year on a combined basis.
	Habilitation services	40% coinsurance	55% coinsurance	Physical therapy, occupational therapy and speech therapy for habilitative purposes are limited to 60 visits per Calendar Year on a combined basis.
	Skilled nursing care	40% coinsurance	55% coinsurance	Limited to 90 days per Calendar Year.
	Durable medical equipment	40% coinsurance	55% coinsurance	Limited to no more than the purchase price. Excludes air conditioners, swimming pools, hot tubs, exercise equipment, or similar equipment.
	Hospice services	40% coinsurance	55% coinsurance	None
If your child needs dental or eye care	Children's eye exam	40% coinsurance	55% coinsurance	Limited to one exam per Calendar Year.
	Children's glasses	40% coinsurance	55% coinsurance	Limited to one pair of lenses and frames per

* For more information about limitations and exceptions, see the plan or policy document at www.wmimutual.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
				Calendar Year.
	Children's dental check-up	40% coinsurance	55% coinsurance	Not subject to Deductible. Limited to one exam every 6 months.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Hearing aids
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Urgent care or emergency care provided outside the United States.

* For more information about limitations and exceptions, see the plan or policy document at www.wmimutual.com.

Your Rights to Continue Coverage: For more information on your rights to continue coverage, contact the plan at 1-800-748-5340. There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Arizona Department of Insurance at 1-800-325-2548 (in-state only but outside of Phoenix) or 602-364-2499, or at www.insurance.az.gov, or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the plan at 1-800-748-5340, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the Arizona Department of Insurance at 1-800-325-2548 (in-state only but outside of Phoenix) or 602-364-2499.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

———————————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*———————————

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3,500
Specialist coinsurance	40%
Hospital (facility) coinsurance	40%
Other coinsurance	40%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,840

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,500
Copayments	$0
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$6,060

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,500
Specialist coinsurance	40%
Hospital (facility) coinsurance	40%
Other coinsurance	40%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,460

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,500
Copayments	$0
Coinsurance	$1,680
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$5,240

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,500
Specialist coinsurance	40%
Hospital (facility) coinsurance	40%
Other coinsurance	40%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,010

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,010
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,010

The plan would be responsible for the other costs of these EXAMPLE covered services.