
 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](http://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](http://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 <a href="#">deductible</a> ?	\$6,900 person/ \$13,800 family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this plan begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Preferred provider preventive care and preventive pediatric dental are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	Yes. \$1,000 person/ \$2,000 family for <a href="#">prescription drug coverage</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$7,900 person/\$15,800 family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members on the <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	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 <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.azfmc.com">www.azfmc.com</a> or call 1-800-748-5340 for a list of preferred providers.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	50% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	50% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	0% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	<a href="#">Deductible</a> does not apply to preferred provider preventive care.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	50% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	50% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	None
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at 1-800-748-5340.	Generic drugs	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	If a generic drug is available, the <a href="#">plan</a> pays equal to the generic amount and the patient pays the difference.
	Brand drugs	90% <a href="#">coinsurance</a>	90% <a href="#">coinsurance</a>	
	<a href="#">Specialty drugs</a>	90% <a href="#">coinsurance</a>	90% <a href="#">coinsurance</a>	Self-injectable drugs are paid under the <a href="#">prescription drug</a> benefit even if they are administered by a <a href="#">provider</a> .  For patient-administered cancer treatment medications, including medications that are orally-administered or self-injected, coinsurance is 20% after deductible.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	50% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	50% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	Non-preferred provider services will be paid at the preferred provider coinsurance if services are for a life-threatening condition.
	<a href="#">Emergency medical transportation</a>	50% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	50% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	50% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	A 10% penalty applies for non-emergency admissions that are not pre-certified. *See

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				section IV, A of the policy.
	Physician/surgeon fees	50% <u>coinsurance</u>	60% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	50% <u>coinsurance</u>	60% <u>coinsurance</u>	None
	Mental/Behavioral health inpatient services	50% <u>coinsurance</u>	60% <u>coinsurance</u>	None
	Substance abuse inpatient services	50% <u>coinsurance</u>	60% <u>coinsurance</u>	None
	Substance abuse outpatient services	50% <u>coinsurance</u>	60% <u>coinsurance</u>	None
If you are pregnant	Office visits	50% <u>coinsurance</u>	60% <u>coinsurance</u>	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	50% <u>coinsurance</u>	60% <u>coinsurance</u>	
	Childbirth/delivery facility services	50% <u>coinsurance</u>	60% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	50% <u>coinsurance</u>	60% <u>coinsurance</u>	None
	<a href="#">Rehabilitation services</a>	50% <u>coinsurance</u>	60% <u>coinsurance</u>	Physical therapy, occupational therapy and speech therapy for rehabilitative purposes are limited to 60 visits per Calendar Year on a combined basis.
	<a href="#">Habilitation services</a>	50% <u>coinsurance</u>	60% <u>coinsurance</u>	Physical therapy, occupational therapy and speech therapy for habilitative purposes are limited to 60 visits per Calendar Year on a combined basis.
	<a href="#">Skilled nursing care</a>	50% <u>coinsurance</u>	60% <u>coinsurance</u>	Limited to 90 days per Calendar Year.
	<a href="#">Durable medical equipment</a>	50% <u>coinsurance</u>	60% <u>coinsurance</u>	Limited to no more than the purchase price. Excludes air conditioners, swimming pools, hot tubs, exercise equipment, or similar equipment.
	<a href="#">Hospice services</a>	50% <u>coinsurance</u>	60% <u>coinsurance</u>	None
If your child needs dental or eye care	Children's eye exam	50% <u>coinsurance</u>	60% <u>coinsurance</u>	Limited to one exam per Calendar Year.
	Children's glasses	50% <u>coinsurance</u>	60% <u>coinsurance</u>	Limited to one pair of lenses and frames per

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		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
				Calendar Year.
	Children's dental check-up	50% <u>coinsurance</u>	60% <u>coinsurance</u>	Not subject to Deductible. Limited to one exam every 6 months.

**Excluded Services & Other Covered Services:**

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)			
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Cosmetic surgery</li> <li>• Dental care</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Infertility treatment</li> <li>• Long term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine eye care</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)	
<ul style="list-style-type: none"> <li>• Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>• Urgent care or emergency care provided outside the United States.</li> </ul>

**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](http://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](http://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](http://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](http://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](#) \$6,900
- [Specialist](#) [coinsurance](#) 50%
- Hospital (facility) [coinsurance](#) 50%
- Other [coinsurance](#) 50%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$6,900
Copayments	\$0
Coinsurance	\$1,700
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$8,660</b>

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

- The [plan's](#) overall [deductible](#) \$6,900
- [Specialist](#) [coinsurance](#) 50%
- Hospital (facility) [coinsurance](#) 50%
- Other [coinsurance](#) 50%

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*)

<b>Total Example Cost</b>	<b>\$5,660</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,600
Copayments	\$0
Coinsurance	\$1,600
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$5,220</b>

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

- The [plan's](#) overall [deductible](#) \$6,900
- [Specialist](#) [coinsurance](#) 50%
- Hospital (facility) [coinsurance](#) 50%
- Other [coinsurance](#) 50%

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

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>