
 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> ?	\$3,000	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. <a href="#">Deductible</a> is waived for preventive services until the plan has paid \$500 towards those services. It never applies to routine well baby care.	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?	No.	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> ?	\$6,000	The <a href="#">out-of-pocket</a> limit 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.fchn.com">www.fchn.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	40% <a href="#">coinsurance</a>	55% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	40% <a href="#">coinsurance</a>	55% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	20% <a href="#">coinsurance</a> for well baby visits through 2 years of age; 40% <a href="#">coinsurance</a> otherwise. 20% <a href="#">coinsurance</a> for childhood and influenza immunizations; 40% <a href="#">coinsurance</a> for other adult immunizations.	40% <a href="#">coinsurance</a> for well baby visits through 2 years of age; 55% <a href="#">coinsurance</a> otherwise. 40% <a href="#">coinsurance</a> for childhood and influenza immunizations; 55% <a href="#">coinsurance</a> for other adult immunizations.	<a href="#">Deductible</a> never applies to well baby/well child visits through 7 years of age.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	40% <a href="#">coinsurance</a>	55% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	40% <a href="#">coinsurance</a>	55% <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	100% <a href="#">coinsurance</a>	100% <a href="#">coinsurance</a>	Not covered
	Brand drugs	100% <a href="#">coinsurance</a>	100% <a href="#">coinsurance</a>	
	<a href="#">Specialty drugs</a>	100% <a href="#">coinsurance</a>	100% <a href="#">coinsurance</a>	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% <a href="#">coinsurance</a>	55% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	55% <a href="#">coinsurance</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	40% <a href="#">coinsurance</a>	55% <a href="#">coinsurance</a>	None
	<a href="#">Emergency medical transportation</a>	40% <a href="#">coinsurance</a>	55% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	40% <a href="#">coinsurance</a>	55% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	40% <a href="#">coinsurance</a>	55% <a href="#">coinsurance</a>	A 10% penalty applies for non-emergency admissions that are not pre-certified. *See

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% <u>coinsurance</u>	55% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	40% <u>coinsurance</u>	55% <u>coinsurance</u>	None
	Mental/Behavioral health inpatient services	40% <u>coinsurance</u>	55% <u>coinsurance</u>	None
	Substance abuse inpatient services	40% <u>coinsurance</u>	55% <u>coinsurance</u>	None
	Substance abuse outpatient services	40% <u>coinsurance</u>	55% <u>coinsurance</u>	None
If you are pregnant	Office visits	40% <u>coinsurance</u>	55% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	40% <u>coinsurance</u>	55% <u>coinsurance</u>	
	Childbirth/delivery facility services	40% <u>coinsurance</u>	55% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	40% <u>coinsurance</u>	55% <u>coinsurance</u>	Limited to 90 visits per Calendar Year.
	<a href="#">Rehabilitation services</a>	40% <u>coinsurance</u>	55% <u>coinsurance</u>	None
	<a href="#">Habilitation services</a>	40% <u>coinsurance</u>	55% <u>coinsurance</u>	None
	<a href="#">Skilled nursing care</a>	40% <u>coinsurance</u>	55% <u>coinsurance</u>	None
	<a href="#">Durable medical equipment</a>	50% <u>coinsurance</u>	50% <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>	40% <u>coinsurance</u>	55% <u>coinsurance</u>	None
If your child needs dental or eye care	Children's eye exam	100% <u>coinsurance</u>	100% <u>coinsurance</u>	Coverage is only available if the optional vision/dental policies have been chosen.
	Children's glasses			
	Children's dental check-up			

**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](#).)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside the U.S.
- Prescription Drugs
- Private-duty nursing
- Routine eye care (Adult)
- 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.)

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

**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 Office of the Commissioner of Securities & Insurance at 1-800-332-6148 (in-state only) or at [www.csi.mt.gov](http://www.csi.mt.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). Additionally, a consumer assistance program can help you file your appeal. Contact the Office of the Commissioner of Securities & Insurance at 1-800-332-6148 (in-state only) or at [www.csi.mt.gov](http://www.csi.mt.gov).

**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](#) \$3,000
- [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*)

<b>Total Example Cost</b>	<b>\$12,840</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$3,000
<i>What isn't covered</i>	
Limits or exclusions	\$100
<b>The total Peg would pay is</b>	<b>\$6,100</b>

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

- The [plan's](#) overall [deductible](#) \$3,000
- [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*)

<b>Total Example Cost</b>	<b>\$7,460</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$4,360
<b>The total Joe would pay is</b>	<b>\$7,400</b>

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

- The [plan's](#) overall [deductible](#) \$3,000
- [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*)

<b>Total Example Cost</b>	<b>\$2,010</b>
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In this example, Mia would pay:

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