



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> ?                                | \$2,500 person/\$5,000 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. <a href="#">Deductible</a> never applies to preferred provider services or to well baby/well child visits through 7 years of age. <a href="#">Deductible</a> is waived for other non-preferred preventive services until the plan has paid \$500 towards those services. | 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> ? | \$5,000 person/\$10,000 family                                                                                                                                                                                                                                                | 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<br>(You will pay the least) | Non-Preferred Provider<br>(You will pay the most)                                                                                                                                                                             |                                                                                                                                                                                                                                                        |
| If you visit a health care <u>provider's</u> office or clinic                                                                                    | Primary care visit to treat an injury or illness | 40% <u>coinsurance</u>                         | 55% <u>coinsurance</u>                                                                                                                                                                                                        | None                                                                                                                                                                                                                                                   |
|                                                                                                                                                  | <u>Specialist</u> visit                          | 40% <u>coinsurance</u>                         | 55% <u>coinsurance</u>                                                                                                                                                                                                        | None                                                                                                                                                                                                                                                   |
|                                                                                                                                                  | <u>Preventive care/screening/immunization</u>    | 0% <u>coinsurance</u>                          | 40% <u>coinsurance</u> for well baby visits through 2 years of age; 55% <u>coinsurance</u> otherwise. 40% <u>coinsurance</u> for childhood and influenza immunizations; 55% <u>coinsurance</u> for other adult immunizations. | <u>Deductible</u> never applies to preferred provider services or to well baby/well child visits through 7 years of age. <u>Deductible</u> is waived for other non-preferred preventive services until the plan has paid \$500 towards those services. |
| If you have a test                                                                                                                               | <u>Diagnostic test</u> (x-ray, blood work)       | 40% <u>coinsurance</u>                         | 55% <u>coinsurance</u>                                                                                                                                                                                                        | None                                                                                                                                                                                                                                                   |
|                                                                                                                                                  | Imaging (CT/PET scans, MRIs)                     | 40% <u>coinsurance</u>                         | 55% <u>coinsurance</u>                                                                                                                                                                                                        | None                                                                                                                                                                                                                                                   |
| If you need drugs to treat your illness or condition<br>More information about <u>prescription drug coverage</u> is available at 1-800-748-5340. | Generic drugs                                    | 25% <u>coinsurance</u>                         | 25% <u>coinsurance</u>                                                                                                                                                                                                        | None                                                                                                                                                                                                                                                   |
|                                                                                                                                                  | Brand drugs                                      | 50% <u>coinsurance</u>                         | 50% <u>coinsurance</u>                                                                                                                                                                                                        | None                                                                                                                                                                                                                                                   |
|                                                                                                                                                  | <u>Specialty drugs</u>                           | Same as above for generic and brand drugs      | Same as above for generic and brand drugs                                                                                                                                                                                     | Self-injectable drugs are paid under the prescription drug benefit even if they are administered by a provider.                                                                                                                                        |
| If you have outpatient surgery                                                                                                                   | Facility fee (e.g., ambulatory surgery center)   | 40% <u>coinsurance</u>                         | 55% <u>coinsurance</u>                                                                                                                                                                                                        | None                                                                                                                                                                                                                                                   |
|                                                                                                                                                  | Physician/surgeon fees                           | 40% <u>coinsurance</u>                         | 55% <u>coinsurance</u>                                                                                                                                                                                                        | None                                                                                                                                                                                                                                                   |
| If you need immediate medical attention                                                                                                          | <u>Emergency room care</u>                       | 40% <u>coinsurance</u>                         | 55% <u>coinsurance</u>                                                                                                                                                                                                        | None                                                                                                                                                                                                                                                   |
|                                                                                                                                                  | <u>Emergency medical transportation</u>          | 40% <u>coinsurance</u>                         | 55% <u>coinsurance</u>                                                                                                                                                                                                        | None                                                                                                                                                                                                                                                   |

| Common Medical Event                                                      | Services You May Need                        | What You Will Pay                              |                                                   | Limitations, Exceptions, & Other Important Information                                                                                     |
|---------------------------------------------------------------------------|----------------------------------------------|------------------------------------------------|---------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                              | Preferred Provider<br>(You will pay the least) | Non-Preferred Provider<br>(You will pay the most) |                                                                                                                                            |
|                                                                           | <a href="#">Urgent care</a>                  | 40% <u>coinsurance</u>                         | 55% <u>coinsurance</u>                            | None                                                                                                                                       |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)           | 40% <u>coinsurance</u>                         | 55% <u>coinsurance</u>                            | A 10% penalty applies for non-emergency admissions that are not pre-certified. *See 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  |                                                |                                                   |                                                                                                                                            |
|                                                                           | Substance abuse inpatient services           |                                                |                                                   |                                                                                                                                            |
|                                                                           | Substance abuse outpatient services          |                                                |                                                   |                                                                                                                                            |
| 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                          | 0% <u>coinsurance</u>                          | 55% <u>coinsurance</u>                            | One visual screening is covered for children under age 5.                                                                                  |
|                                                                           | Children's glasses                           | 100% coinsurance                               | 100% coinsurance                                  | Coverage is only available if the optional vision/dental policies have been chosen.                                                        |
|                                                                           | 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                               | • Infertility treatment                              | • Private-duty nursing     |
| • Cosmetic surgery                                | • Long term care                                     | • Routine eye care (Adult) |
| • Dental care (Adult)                             | • Non-emergency care when traveling outside the U.S. | • Routine foot care        |
| • Hearing aids (except for children under age 19) | • Prescription Drugs                                 | • 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**

[Minimum Essential Coverage](#) generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the premium tax credit.

**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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$2,500 |
| ■ <a href="#">Specialist</a> coinsurance                        | 40%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 40%     |
| ■ Other <a href="#">coinsurance</a>                             | 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>\$12,700</b> |
|---------------------------|-----------------|

#### In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$2,500        |
| Copayments                        | \$0            |
| Coinsurance                       | \$2,500        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$5,060</b> |

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$2,500 |
| ■ <a href="#">Specialist</a> coinsurance                        | 40%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 40%     |
| ■ Other <a href="#">coinsurance</a>                             | 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>\$5,660</b> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$2,500        |
| Copayments                        | \$0            |
| Coinsurance                       | \$1,400        |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$3,920</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$2,500 |
| ■ <a href="#">Specialist</a> coinsurance                        | 40%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 40%     |
| ■ Other <a href="#">coinsurance</a>                             | 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>\$2,800</b> |
|---------------------------|----------------|

#### In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$2,500        |
| Copayments                        | \$0            |
| Coinsurance                       | \$100          |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,600</b> |