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?	**$750** person/ **$1,500** 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. Network preventive care is 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.
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?	**$7,500** person/**$15,000** 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, deductible amounts, balance-billing charges (unless balance billing is prohibited), copayment amounts, 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/wmitpa.

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
		Network Provider (You will pay the least)	Non-Network 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	$30 copayment	30% coinsurance	None
	Specialist visit	$30 copayment	30% coinsurance	None
	Preventive care/screening/ immunization	$30 copayment	30% coinsurance	Deductible applies to non-network services.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% 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	$13 copayment	100% coinsurance	Deductible does not apply to these services. The copayment amount is doubled for mail order drugs.
	Brand drugs	$22 copayment for a formulary drug, $45 copayment for a non-formulary drug	100% coinsurance	Deductible does not apply to these services. The copayment amount is doubled for mail order drugs. If a generic drug is available, the plan pays equal to the generic amount and the patient pays the difference.
	Specialty drugs	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)	10% coinsurance	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance	30% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	10% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	A 10% penalty applies for non-emergency admissions that are not pre-certified. *See the Utilization Review section of the policy.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	10% coinsurance	30% coinsurance	None
	Mental/Behavioral health inpatient services			
	Substance abuse inpatient services			
	Substance abuse outpatient services			
If you are pregnant	Office visits	$30 copayment	30% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Pregnancy is not covered for dependent daughters.
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Limited to 100 visits per calendar year.
	Rehabilitation services	20% coinsurance	20% coinsurance	None
	Habilitation services	100% coinsurance	100% coinsurance	Not covered.
	Skilled nursing care	20% coinsurance	20% coinsurance	Limited to 90 days per calendar year.
	Durable medical equipment	20% coinsurance	20% coinsurance	Limited to no more than the purchase price.
	Hospice services	20% coinsurance	20% coinsurance	None
If your child needs dental or eye care	Children's eye exam	$30 copayment	30% coinsurance	Deductible applies to non-network services. Benefit is for well-child only.
	Children's glasses	100% coinsurance	100% coinsurance	These services are not covered.
	Children's dental check-up			

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

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
- Infertility treatment
- Long term care
- Care or treatment when traveling outside the U.S for the sole purpose of obtaining medical care
- Private-duty nursing
- Routine eye care
- Routine foot care
- Weight loss program

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

- Chiropractic care
- Hearing aids
- Urgent/Emergency and medically necessary, non-elective care or treatment, when traveling outside the U.S.

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

Your Rights to Continue Coverage: For more information on your rights to continue coverage, contact the plan at 928-428-2192. There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 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 928-428-2192, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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.*———————————

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

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	$750
Specialist copayment	$30
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$60
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,370

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

The plan's overall deductible	$750
Specialist copayment	$30
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$5,660

In this example, Joe would pay:

Cost Sharing	
Deductibles	$750
Copayments	$800
Coinsurance	$30
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,600

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

The plan's overall deductible	$750
Specialist copayment	$30
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Copayments	$100
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,150

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