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, www.dol.gov/ebsa. 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.healthcare.gov/sbc-glossary or call 1-800-777-7898 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$150 individual/$300 family per calendar year. Doesn't apply to preventive care or RX plan.	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. Preventive care services 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. List of covered preventive services at http://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $500 for infertility treatment. There are no other specific deductibles.	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?	$12,500 individual/$25,000 family.	The Out-of-Pocket limit is the most you could pay in a year for covered services. If you have other family members in this 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?	Copays, deductibles, premiums, balance-billed charges, non-participating hospitals, pre-authorization penalties 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.anthem.com/ca for California, www.azblue.com for Arizona, www.firsthealth.com for remaining states or call 1-800-777-7898.	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 a Non-Participating 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 a Non-Participating 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.wga.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: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit	20% coinsurance	Participating provider(s) are not subject to the deductible.
	Specialist visit	$15 copay/visit	20% coinsurance	Office visit exam only. Participating provider(s) are not subject to the deductible.
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.prxsolutions.com	Generic drugs	$10 copay/prescription for retail and $20 copay/prescription for mail order	Not Covered	Pharmacy deductible: None. Retail: 30 day supply. Mail order (maintenance drugs only): 90 day supply.
	Preferred brand drugs	$25 copay/prescription for retail and $50 copay/prescription for mail order	Not Covered	Pharmacy deductible: None. Retail: 30 day supply. Mail order (maintenance drugs only): 90 day supply. Mandatory Generic Substitution.
	Non-preferred brand drugs	Copay equal to 40% of negotiated fee, with a minimum copay of $35	Not Covered	Pharmacy deductible: None. Retail: 30 day supply. Not available for mail order. Pre-authorization required.
	Specialty drugs	10% Copay for oral medications / 20% Copay for self injectables	Not Covered	Pharmacy deductible: None. Classified specialty drugs must be obtained through the specialty pharmacy up to a 30-day maximum. Pre-authorization required.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Pre-authorization required for surgery in a non-participating hospital or an extra $250 copay per occurrence will be incurred and will not apply to your Out-of-Pocket.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	$100 Copay for each illness or accident, then 20% coinsurance	$100 Copay for each illness or accident, then 20% coinsurance. $100 copay and 40% coinsurance for non-emergency services.	The Copay is waived if admitted to the hospital or within 48 hours of the Accident.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$15 copay/visit	20% coinsurance	Office visit exam only. Participating Provider(s) are not subject to the deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Pre-authorization required or benefit reduced by 50% and will not apply to your Out-of-Pocket. A copay equal to the deductible applies for Non-Participating facilities.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/visit	20% coinsurance	Participating provider(s) are not subject to the deductible.
	Inpatient services	20% coinsurance	40% coinsurance	Pre-authorization required or benefit reduced by 50% and will not apply to your Out-of-Pocket. A copay equal to the deductible applies for Non-Participating facilities.
If you are pregnant	Office visits	$15 copay/visit	20% coinsurance	Cost sharing does not apply to certain preventive services.
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	None

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

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	A copay equal to the deductible applies for Non-Participating facilities. Pre-authorization required for inpatient maternity stays over 48 hours (normal delivery) or 96 hours (c-section) or benefit reduced by 50% and will not apply to your Out-of-Pocket.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	60 visits per calendar year. Pre-authorization required.
	Rehabilitation services	20% coinsurance	20% coinsurance	Pre-authorization required.
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	20% coinsurance	20% coinsurance	Benefit Maximum of 20 days per calendar year. Pre-authorization required or benefit reduced by 50% and will not apply to your Out-of-Pocket.
	Durable medical equipment	20% coinsurance	20% coinsurance	Pre-authorization required for charges exceeding $500.
	Hospice services	20% coinsurance	40% coinsurance	Pre-authorization required or benefit reduced by 50% and will not apply to your Out-of-Pocket.

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.)

- Cosmetic Surgery
- Dental Care
- Hearing Aids
- 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.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Infertility Treatment

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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.

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

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 on how 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: Western Growers Assurance Trust at 1-800-777-7898 or www.wgat.com or 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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-777-7898.

*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.wga.com.

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	**$150**
Specialist coinsurance	**$15**
Hospital (facility) coinsurance	**20%**

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	**$150**
Copayments	**$10**
Coinsurance	**$2500**
What isn't covered	
Limits or exclusions	**$60**
The total Peg would pay is	**$2720**

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

The plan's overall deductible	**$150**
Specialist copay	**$15**
Hospital (facility) coinsurance	**20%**

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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	**$150**
Copayments	**$400**
Coinsurance	**$200**
What isn't covered	
Limits or exclusions	**$20**
The total Joe would pay is	**$770**

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

The plan's overall deductible	**$150**
Specialist copay	**$15**
Hospital (facility) coinsurance	**20%**

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	**$150**
Copayments	**$50**
Coinsurance	**$500**
What isn't covered	
Limits or exclusions	**$0**
The total Mia would pay is	**$700**

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