This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.wgat.com or by calling 1-800-777-7898.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$150** person / **$300** family per calendar year. Doesn't apply to preventive care or RX plan.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
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.
Is there an out-of-pocket limit on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out-of-pocket limit?	The plan has no **out-of-pocket limit**.	Not applicable because there's no **out-of-pocket limit** on your expenses.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.anthem.com/ca** for California, **www.azblue.com** for Arizona, **www.multiplan.com** for remaining states or call **1-800-777-7898**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay / visit	40% coinsurance	Office visit exam only.
	Specialist visit	$15 copay / visit	40% coinsurance	Office visit exam only.
	Other practitioner office visit	20% coinsurance for chiropractor and acupuncture	20% coinsurance for chiropractor and acupuncture	Acupuncture: Pain management only. Chiropractic: $500 Maximum per Calendar year, $75 maximum for x-rays.
	Preventive care/screening/immunization	No Charge	Not Covered	Must use a participating provider. One routine exam / Calendar Year.
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———————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available by calling 1-800-777-7898.	Generic drugs	$10 copay/prescription for retail and $20 copay/prescription for mail order	$10 copay/prescription for retail and $20 copay/prescription for mail order	Covers up to a 30-day supply (retail prescription); up to 90 day supply (mail order prescription).
	Brand name drugs	$25 copay/prescription for retail and $50 copay/prescription for mail order	$25 copay/prescription for retail and $50 copay/prescription for mail order	Mandatory Generic Substitution.
	Non-Formulary drugs	Copay equal to 40% of negotiated fee, with a minimum copay of $35	Copay equal to 40% of negotiated fee, with a minimum copay of $35	Not available for mail order.
	Specialty drugs	10% Copay for oral medications / 20% Copay for self injectables	10% Copay for oral medications / 20% Copay for self injectables	Not available for mail order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Pre-certification required 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 services	$100 Copay for each illness or accident, then 20% coinsurance	$100 Copay for each illness or accident, then 20% coinsurance	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	20% coinsurance	40% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Pre-certification required or benefit reduced by 50% and will not apply to your out-of-pocket. Non-Participating Facility, a copay equal to the deductible is charged to you.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 copay / visit and 20% coinsurance other services	40% coinsurance	————none————
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	Pre-certification required or benefit reduced by 50% and will not apply to your out-of-pocket. Non-Participating Facility, a copay equal to the deductible is charged to you.
	Substance use disorder outpatient services	$15 copay / visit and 20% coinsurance other services	40% coinsurance	————none————
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	Pre-certification required or benefit reduced by 50% and will not apply to your out-of-pocket. Non-Participating Facility, a copay equal to the deductible is charged to you.
If you are pregnant	Prenatal and postnatal care	$15 copay / visit	40% coinsurance	————none————
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Pre-certification required or benefit reduced by 50% and will not apply to your out-of-pocket. Non-Participating Facility, a copay equal to the deductible is charged to you.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Benefit Maximum of 60 four hour days per calendar year.
	Rehabilitation services	20% coinsurance	20% coinsurance	————none————
	Habilitation services	Not Covered	Not Covered	————none————
	Skilled nursing care	20% coinsurance	20% coinsurance	Benefit Maximum of $2,000 per calendar year.
	Durable medical equipment	20% coinsurance	20% coinsurance	Pre-certification required for charges exceeding $500.
	Hospice service	20% coinsurance	40% coinsurance	Pre-certification required.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	————none————
	Glasses	Not Covered	Not Covered	————none————
	Dental check-up	Not Covered	Not Covered	————none————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic Surgery
- Dental care (Adult)
- Habilitation
- Hearing Aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine Foot Care
- Routine eye care (Adult)

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Chiropractic Care
- Infertility treatment
- Bariatric Surgery
- Weight loss programs

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-777-7898 or www.wgat.com. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can 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 Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does not provide minimum essential coverage.**

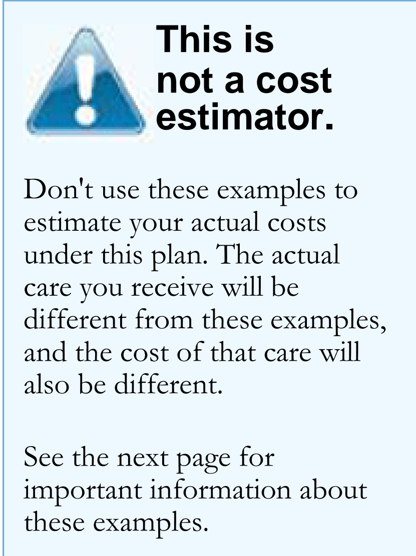
Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to , in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,760
- **Patient pays** $1,780

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$150
Copays	$20
Coinsurance	$1,420
Limits or exclusions	$190
Total	**$1,780**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,230
- **Patient pays** $1,170

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$150
Copays	$550
Coinsurance	$250
Limits or exclusions	$220
Total	**$1,170**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: Western Growers Assurance Trust at 1-800-777-7898.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✖ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✖ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.