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.
Are there other deductibles for specific services?	Yes. **$500** 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, mental health, non-participating hospitals, injectable medications, 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 Participating provider?	Yes. See **www.anthem.com** for California or www.azblue.com for Arizona or 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.

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
		Participating Provider (You will pay the least)	Non-Participating 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	$15 copay / visit	20% coinsurance	Office visit exam only. 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	Must use a participating provider.
	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.
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	Preauthorization is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-877-782-9658	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). Cost sharing does not apply to federally-required preventive care medications or as otherwise specifically indicated in your summary plan description.
	Preferred brand 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. Cost sharing does not apply to federally-required preventive care medications or as otherwise specifically indicated in your summary plan description.
	Non-preferred brand 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. Cost sharing does not apply to federally-required preventive care medications or as otherwise specifically indicated in your summary plan description. Preauthorization is required. Failure to obtain preauthorization may result in reduction or non-payment of benefits.
	Specialty drugs	10% Copay for oral	10% Copay for oral	Classified specialty drugs must be obtained through the

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
		medications / 20% Copay for self injectables	medications / 20% Copay for self injectables	specialty pharmacy up to a 30-day maximum. Cost sharing does not apply to federally-required preventive care medications or as otherwise specifically indicated in your summary plan description. Preauthorization is required. Failure to obtain preauthorization may result in reduction or non-payment of benefits.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Pre-authorization 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 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	20% coinsurance	40% coinsurance	None
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. Non-Participating Facility, a copay equal to the deductible is charged to you.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay / visit and 20% coinsurance other services	40% coinsurance	Office visit exam only. Participating Provider(s) are not subject to the deductible.
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization required or benefit reduced by 50% and will not apply to your Out-of-Pocket.
If you are pregnant	Office visits	$15 copay / visit	40% coinsurance	Office visit exam only. Participating Provider(s) are not subject to the deductible. Preventive services related to pregnancy, such as preconception and prenatal care are covered at 100% when you use a participating provider.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Childbirth/delivery	20% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	60 visits per calendar year. Preauthorization required.
	Rehabilitation services	20% coinsurance	20% coinsurance	Preauthorization required
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	20% coinsurance	20% coinsurance	Benefit Maximum of 10 days per calendar year. Pre-authorization required or the benefit will be 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	Preauthorization required or benefit reduced by 50% and will not apply to your Out-of-Pocket.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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 (Adult) • Routine Foot Care • Weight Loss Programs

Excluded Services & Other Covered Services:

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 Treatments

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.

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: 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**.
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 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	$150
Specialist copayment	$15
Hospital (facility) coinsurance	20%
Other 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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$150
Copayments	$70
Coinsurance	$2480
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2760**

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 copayment	$15
Hospital (facility) coinsurance	20%
Other 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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$150
Copayments	$790
Coinsurance	$370
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1370**

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

The plan's overall deductible	$150
Specialist copayment	$15
Hospital (facility) coinsurance	20%
Other 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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$150
Copayments	$50
Coinsurance	$330
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$530**

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