WESTERN GROWERS ASSURANCE TRUST

Summary of Benefits Covered
Bronze 6350-15

Summary of Features	In-Network	Out-of Network
Calendar Year Deductible ***Integrated with Pharmacy*** In-Network and Out-of-Network **Deductibles are Separate**	Individual: $6,350 Family: $12,700	Individual: $12,700 Family: $25,400
Percentage Payable	100% of Negotiated Contract Rate	50% of Reasonable and Customary
Out-of-Pocket - per Calendar Year Maximum	Individual: $6,350 Family: $12,700	No Limit
Doctor Visit - Primary Care Physician (PCP) Excludes Preventative and X-Rays	First 5 visits $15 copay and deductible waived Additional visits 100% of Negotiated Contract Rate after deductible	50% of Reasonable and Customary after Deductible
Doctor Visit - Specialist	100% of Negotiated Contract Rate after Deductible	50% of Reasonable and Customary after Deductible
Inpatient Care - Includes charges billed by the Hospital for Room & Board, Ancillary Charges and Intensive Care Requires Pre-Authorization for Par and Non-Par Admissions (includes Mental Behavioral Health and Substance Abuse)	100% of Negotiated Contract Rate after Deductible	50% of Reasonable and Customary after Deductible
Outpatient Care - Emergency Room for Illness Deductible and copays apply for Par and Non-Par Providers	100% of Negotiated Contract Rate after Deductible	50% of Reasonable and Customary after Deductible
Emergency Room for an Emergency	100% of Negotiated Contract Rate after Deductible	100% of Participating Providers' Negotiated Contract Rate by Geographical Area after Deductible
Mental and Nervous and Substance Abuse Disorder Outpatient Services	100% of Negotiated Contract Rate Not subject to Deductible	Not a Covered Expense
Cat Scans, MRI's, MRA's, Bone Density, PET Scans **Requires Pre-Authorization**	100% of Negotiated Contract Rate after Deductible	50% of Reasonable and Customary after Deductible
Physical, Occupational, and Speech Therapy **Requires Pre-Authorization**	100% of Negotiated Contract Rate after Deductible	50% of Reasonable and Customary after Deductible
Preventative Care / Screening / Immunization	100% of Negotiated Contract Rate	Not a Covered Expense
Laboratory	$25 copay, then 100% of Negotiated Contract Rate Not subject to Deductible	50% of Reasonable and Customary after Deductible
Diagnostic X-Ray	100% of Negotiated Contract Rate after Deductible	50% of Reasonable and Customary after Deductible
Skilled Nursing - 10 Day Maximum per Calendar Year **Requires Pre-Authorization**	100% of Negotiated Contract Rate after Deductible	50% of Reasonable and Customary after Deductible
Surgery Centers - **Requires Pre-Authorization**	100% of Negotiated Contract Rate after Deductible	50% of Reasonable and Customary after Deductible
Surgeon / Assistant Surgeon / Anesthesia / Doctor Hospital Visit	100% of Negotiated Contract Rate after Deductible	50% of Reasonable and Customary after Deductible
Pediatric Dental Care - up to age 19	**In-Network**	**Out-of-Network**
Deductible	$0	Not a Covered Expense
Annual Out-of-Pocket	$1,000/Child - $2,000/Children Separate from medical plan OOP	Not a Covered Expense
Office Visit	100%	Not a Covered Expense
Preventive - periodic (2 per Calendar Year) and comprehensive oral evaluation, bitewing X-rays, prophylaxis cleanings, space maintainers, and sealants	100%	Not a Covered Expense
Fluoride Treatments	100%	Not a Covered Expense
Restorative Fillings - primary or permanent amalgam	50%	Not a Covered Expense
Composite Crowns - resin based	50%	Not a Covered Expense
Crowns- porcelain	50%	Not a Covered Expense
Inlay- metallic	50%	Not a Covered Expense
Orthodontics (only if medically necessary)	$1,000	Not a Covered Expense
Pediatric Eye Care - up to age 19	**In-Network**	**Out-of-Network**
Eye Exam - 1 per Calendar Year	100%	Not a Covered Expense
Glasses	1 Pair per Calendar Year	Not a Covered Expense
Prescription Drugs	**Pinnacle Rx Solutions**	
Maximum 30-day Supply	**Participating Pharmacies Only - Generic Coverage Only**	
Generic (deductible waived)	$15 copay per medication	
Preferred Brand (Formulary)	Not Covered*	
Non-Preferred Brand (Non-Formulary)	Not Covered*	
Specialty	50% coinsurance after deductible met	
Mail Order Program - Maximum 90 Day Supply	**Approved Maintenance Medication Only**	
Generic (deductible waived)	$30 copay per medication	
Preferred Brand (Formulary)	Not Covered	

PLEASE CALL OUR WGAT CUSTOMER SERVICE DEPARTMENT AT (800) 777-7898 FOR FURTHER INFORMATION.

NOTE: This outline is for use as a reference only and is a summary of available benefits. It is not a contract. All benefits referenced are subject to any applicable exclusions and/or limitations in your Western Growers Assurance Trust Summary Benefit Description and member eligibility at the time services are rendered.

REASONABLE AND CUSTOMARY: Covered Expense for Medically Necessary services or supplies essential to the care of the patient not to exceed 125% of the Medicare's Resource Based Relative Value Scale (RBRVS), payable at Plan Percentage.

*Coverage may be provided if an alternative generic is not available by contacting Pinnacle Rx Solutions for a prior authorization.

Effective 07/01/2014