



Summary of Benefits Covered Platinum 2000-00

Summary of Features	In-Network	Out-of Network
Calendar Year Deductible In-Network and Out-of-Network Deductibles are Separate	Individual: \$250 Family: \$500	Individual: \$500 Family: \$1,000
Percentage Payable	85% of Negotiated Contract Rate	60% of Reasonable and Customary
Out-of-Pocket - per Calendar Year Maximum	Individual: \$2,000 Family: \$4,000	No Limit
Doctor Visit - Primary Care Physician (PCP) Excludes Preventative and X-Rays	85% of Negotiated Contract Rate after Deductible	60% of Reasonable and Customary after Deductible
Doctor Visit - Specialist	85% of Negotiated Contract Rate after Deductible	60% 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)	85% of Negotiated Contract Rate after Deductible	60% of Reasonable and Customary after Deductible
Outpatient Care - Emergency Room for Illness Deductible and copays apply for Par and Non-Par Providers	\$250 copay, then 85% of Negotiated Contract Rate after Deductible	\$250 copay, then 60% of Reasonable and Customary after Deductible
Emergency Room for an Emergency	85% of Negotiated Contract Rate after Deductible	85% of Participating Providers' Negotiated Contract Rate by Geographical Area after Deductible
Mental and Nervous and Substance Abuse Disorder Outpatient Services	85% of Negotiated Contract Rate after Deductible	Not a Covered Expense
Cat Scans, MRI's, MRA's, Bone Density, PET Scans Requires Pre-Authorization	85% of Negotiated Contract Rate after Deductible	60% of Reasonable and Customary after Deductible
Physical, Occupational, and Speech Therapy Requires Pre-Authorization	85% of Negotiated Contract Rate after Deductible	60% of Reasonable and Customary after Deductible
Preventative Care / Screening / Immunization	100% of Negotiated Contract Rate	Not a Covered Expense
Laboratory	85% of Negotiated Contract Rate after Deductible	60% of Reasonable and Customary after Deductible
Diagnostic X-Ray	85% of Negotiated Contract Rate after Deductible	60% of Reasonable and Customary after Deductible
Skilled Nursing - 10 Day Maximum per Calendar Year Requires Pre-Authorization	85% of Negotiated Contract Rate after Deductible	60% of Reasonable and Customary after Deductible
Surgery Centers - Requires Pre-Authorization	85% of Negotiated Contract Rate after Deductible	60% of Reasonable and Customary after Deductible
Surgeon / Assistant Surgeon / Anesthesia / Doctor Hospital Visit	85% of Negotiated Contract Rate after Deductible	60% 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	85%	Not a Covered Expense
Composite Crowns - resin based	85%	Not a Covered Expense
Crowns- porcelain	85%	Not a Covered Expense
Inlay- metallic	85%	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 - Requires Mandatory Generic Substitution	
Generic	\$5 copay per medication	
Preferred Brand (Formulary)	\$25 copay per medication	
Non-Preferred Brand (Non-Formulary)	\$50 copay per medication	
Specialty	15%	
Mail Order Program - Maximum 90 Day Supply	Approved Maintenance Medication Only	
Generic	\$10 copay per medication	
Preferred Brand (Formulary)	\$50 copay per medication	

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.

Effective 07/01/2014