



## WESTERN GROCERS EMPLOYEE BENEFITS TRUST

### Comparison of Benefit Options for Major Medical Plans

PLAN OPTIONS - Annual Deductible - Office Visit Co-Pay	CHOICE \$500/\$1000 N/A	PREMIER \$250/\$500 \$20 Office Visits		STANDARD \$500/\$1000 \$20 Office Visits		PRIMARY \$1000/\$2000 \$30 Office Visits	
<b>Physician / Hospital Choice</b>	Any Covered Service / Facility of your choice.	Higher benefits if you use Preferred Provider network (PPO)		Higher benefits if you use Preferred Provider network (PPO)		Higher benefits if you use Preferred Provider network (PPO)	
<b>Lifetime Max Benefit</b> (Optional \$2 mil)	\$1,000,000	\$1,000,000		\$1,000,000		\$1,000,000	
<b>Out of Pocket Expense</b> Max per Person / year Max per Family / year	\$4,000 + Ded \$8,000 + Ded	In Network maximum \$2,000 + Ded \$4,000 + Ded		In Network maximum \$2000 +Ded \$4000 +Ded		In Network maximum \$2000+Ded \$4000+Ded	
<b>In Patient Hosp Benefits</b>		<b><u>In Network</u></b>	<b><u>OUT</u></b>	<b><u>In Network</u></b>	<b><u>OUT</u></b>	<b><u>In Network</u></b>	<b><u>OUT</u></b>
✓ Room stay	80%	80%	60%	80%	60%	80%	60%
✓ Physician Services	80%	80%	60%	80%	60%	80%	60%
✓ Lab and X-ray	80%	80%	60%	80%	60%	80%	60%
✓ Maternity care	80%	80%	60%	80%	60%	80%	60%
<b>Out Patient Benefits</b>		<b><u>In Network</u></b>	<b><u>OUT</u></b>	<b><u>In Network</u></b>	<b><u>OUT</u></b>	<b><u>In Network</u></b>	<b><u>OUT</u></b>
✓ Office Visit	80%	\$ 20	60%	\$ 20	60%	\$ 30	60%
✓ Lab & X-ray	80%	80%	60%	80%	60%	80%	60%
<b>Maternity Care</b>	80%	80%	60%	80%	60%	80%	60%
<b>Outpatient Surgery</b>	80%	80%	60%	80%	60%	80%	60%
<b>⇐ ALL PLANS ⇒</b>							
<b>Ambulance</b>	80% or 60% for usual and customary services for ground ambulance. Air ambulance benefit up to \$5000 per year.						
<b>Emergency Room Services</b>	\$75 Co –Pay after deductible met, waived if hospitalized						
<b>Acupuncture</b>	80% or 60% after deductible up to 12 visits per year						
<b>Naturopathy</b>	80% or 60% after deductible up to 12 visits per year						
<b>Chiropractic Services</b>	\$30 per visit paid for up to 12 visits per year						
<b>Accident Benefits</b>	First \$500 Paid in full without deductible or co-pay						
<b>Mental Health / Chem. Dependency</b>	80% or 60% after deductible including in-patient and outpatient provisions for both adults and children						
<b>Pre-existing Conditions</b>	6 Months waiting period if no previous continuous coverage						
<b>Preventative Care</b>	Mammograms & Pelvic Exams \$15 co-pay ♦ Child exams and immunizations included ♦ All other care - \$300 reimbursement per year						
<b>Prescriptions</b> ✓ Drug card program	\$25 Deductible then; \$10 Co-pay for generic drugs ♦ \$30 co-pay for Preferred Brands ♦ \$50 co-pay for Non-Preferred Brands MAIL ORDER DISCOUNT: 3 prescription fills for 2 co-pays						
<b>Life Insurance</b>	\$10,000 per employee and \$1,000 per family member included in plan ⇨ Optional \$25,000 for employee for additional \$6.75 per month						
<b>Short Term Disability</b>	\$100 per week after 7 day waiting period included in plan ⇨ higher limits are available on request						

NOTE: This document is a summary for illustrative purposes only. Please refer to the complete Plan Booklet for detailed explanations, limitations, exclusions and maximum payment information.