Western Grocers Employee Benefits Trust

Summary of Plan Options Effective 01.01.2021

PacificSource HEALTH PLANS

PacificSource Plan Name *(Prior Name)*	Voyager 500+20-30_20 S2 *(Standard)*	Voyager 1000+30-40_20 S2 *(Primary)*	Voyager 1500+30-40_20 S2 *(Basic)*	Voyager 3000+30-40_20 S2 *(Foundation)*	Voyager 5000+35-45_30 S2 *(Essential)*
	In Network	In Network	In Network	In Network	In Network
Deductible	$500 per person / $1,000 per family	$1,000 per person / $2,000 per family	$1,500 per person / $3,000 per family	$3,000 per person / $6,000 per family	$5,000 per person / $10,000 per family
Out-of-Pocket Maximum	$5,000 per person / $10,000 per family	$5,000 per person / $10,000 per family	$7,100 per person / $14,200 per family	$7,100 per person / $14,200 per family	$7,100 per person / $14,200 per family
Preventive Care					
Well-Baby Care	0% deductible waived	0% deductible waived	0% deductible waived	0% deductible waived	0% deductible waived
Routine Physicals (schedule applies)	0% deductible waived	0% deductible waived	0% deductible waived	0% deductible waived	0% deductible waived
Routine Gynecological Exams	0% deductible waived	0% deductible waived	0% deductible waived	0% deductible waived	0% deductible waived
Immunizations	0% deductible waived	0% deductible waived	0% deductible waived	0% deductible waived	0% deductible waived
Professional Services					
Office Visits (PCP/Specialists)	$20 / $30 co-pay*	$30 / $40 co-pay*	$30 / $40 co-pay*	$30 / $40 co-pay*	$35 / $45 co-pay*
Teladoc	$10 co-pay*	$10 co-pay*	$10 co-pay*	$10 co-pay*	$10 co-pay*
Urgent Care	$20 co-pay*	$30 co-pay*	$30 co-pay*	$30 co-pay*	$35 co-pay*
Surgery	after deductible, 20%	after deductible, 20%	after deductible, 20%	after deductible, 20%	after deductible, 30%
Hospital Services					
Inpatient Hospital	after deductible, $500 plus 20%	after deductible, $500 plus 20%	after deductible, $500 plus 20%	after deductible, $500 plus 20%	after deductible, $500 plus 30%
Inpatient Rehabilitative Care	after deductible, $500 plus 20%	after deductible, $500 plus 20%	after deductible, $500 plus 20%	after deductible, $500 plus 20%	after deductible, $500 plus 30%
Skilled Nursing Facility Care	after deductible, 20%	after deductible, 20%	after deductible, 20%	after deductible, 20%	after deductible, 30%
Outpatient Services					
Outpatient Surgery	after deductible, 20%	after deductible, 20%	after deductible, 20%	after deductible, 20%	after deductible, 30%
CT Scans/MRIs	after deductible, $200 plus 20%	after deductible, $200 plus 20%	after deductible, $200 plus 20%	after deductible, $200 plus 20%	after deductible, $200 plus 30%
Diagnostic, Lab	after deductible, 20%	after deductible, 20%	after deductible, 20%	after deductible, 20%	after deductible, 30%
Emergency Room Visits	after deductible, $75 plus 20%	after deductible, $75 plus 20%	after deductible, $75 plus 20%	after deductible, $75 plus 20%	after deductible, $75 plus 30%
Mental Health/Chemical Dependency					
Office Visits	$20 co-pay*	$30 co-pay*	$30 co-pay*	$30 co-pay*	$35 co-pay*
Inpatient Care	after deductible, $500 plus 20%	after deductible, $500 plus 20%	after deductible, $500 plus 20%	after deductible, $500 plus 20%	after deductible, $500 plus 30%
Residential Programs	after deductible, $500 plus 20%	after deductible, $500 plus 20%	after deductible, $500 plus 20%	after deductible, $500 plus 20%	after deductible, $500 plus 30%
Other Covered Services					
Rehabilitation & Habilitation Services (PT)	after deductible, 20%	after deductible, 20%	after deductible, 20%	after deductible, 20%	after deductible, 30%
Allergy Injections	$5 copay*	$5 copay*	$5 copay*	$5 copay*	$5 copay*
Ambulance, Ground	after deductible 20%	after deductible 20%	after deductible 20%	after deductible 20%	after deductible 30%
Ambulance, Air	after deductible 20%	after deductible 20%	after deductible 20%	after deductible 20%	after deductible 30%
Durable Medical Equipment	after deductible 20%	after deductible 20%	after deductible 20%	after deductible 20%	after deductible 30%
Home Health Care	after deductible 20%	after deductible 20%	after deductible 20%	after deductible 20%	after deductible 30%
Prescription Drugs					
OR 5-35-75 25D S2 ODL (Formulary is Oregon Drug List) - Rx Plan is included with all medical options - Includes PacificSource Expanded No Cost Drug List (Deductible is waived) After Rx Deductible $25 per person (separate from Medical plan deductible, does apply to your medical out of pocket max) Retail 30 day supply - Tier 1 : $5 co-pay / Tier 2 : $35 co-pay / Tier 3 : $75 co-pay / Tier 4 (Specialty Drugs) 50% Mail Order 90-day supply - Tier 1 : $10 co-pay / Tier 2 : $70 co-pay / Tier 3 : $150 co-pay / Tier 4 (Specialty Drugs) 50%				
Accident Benefit					
The first $500 of covered expenses within 90 days of an accident is covered up to the maximum benefit available and not subject to the deductible. The date of injury must occur after the member is enrolled in this plan. The balance is covered by the plan.					
Chiropractic manipulations and acupuncture					
In Network Services are subject to the standard office visit co-payments, Out of Network Services are subject to deductible then coinsurance - 24 visit max per benefit year					
Vision					
Vision Exam - all ages - $25 copay (1 per 24 months) Vision Hardware (Frames & Lenses or Contacts) - 18 and Younger - covered 100% (1 per 24 months) - 19 and Older - Covered up to $300 (1 per 24 months)					
Dental					
Option 1 - Dental Choice Plus 0-20-50 50-1000 w/Ortho 1000 - Class I - 0%, Class II - 20%, Class III, - 50% $50 Deductible applies to Class II & III services, $1000 Annual Max Benefit Orthodontia $1000 Lifetime Benefit Max per person					
Option 2 - Dental Choice Plus 0-20-50 50-1500 w/Ortho 1000 - Class I - 0%, Class II - 20%, Class III, - 50% $50 Deductible applies to Class II & III services, $1500 Annual Max Benefit Orthodontia $1000 Lifetime Benefit Max per person					
Option 3 - Dental Choice Plus 0-20-50 50-2500 w/Ortho 1500 - Class I - 0%, Class II - 20%, Class III, - 50% $50 Deductible applies to Class II & III services, $2500 Annual Max Benefit Orthodontia $1500 Lifetime Benefit Max per person					

** Deductible is waived on these items*

Note: This display is for illustration purposes only. Out of Network benefits can be found on the full plan summaries. Please refer to the member handbook for specific coverage details.