



Western Grocers Employee Benefits Trust

Summary Deductibles, Co-insurance and Office Co-pays In Network - Navigator and Voyager Plans



Plan Reference	500	1000	1500	3000-20	3000-30	5000-30	5000-CAT
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	\$3,000 per person \$6,000 per family	\$5,000 per person \$10,000 per family	\$5,000 per person \$10,000 per family
Co-insurance (you pay after deductible)	20%	20%	20%	20%	30%	30%	50%
Annual Out-of-Pocket Maximum you pay	\$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	\$7,100 per person \$14,200 per family	\$7,900 per person \$15,800 per family
Primary Care Office Visit	\$20 co-pay*	\$30 co-pay*	\$30 co-pay*	\$30 co-pay*	\$30 co-pay*	\$35 co-pay*	\$75 co-pay*
Specialists Office Visit	\$40 co-pay*	\$50 co-pay*	\$50 co-pay*	\$50 co-pay*	\$50 co-pay*	\$55 co-pay*	\$75 co-pay*
Emergency Room visits	Ded / \$150 / 20%	Ded / \$150 / 20%	Ded / \$150 / 20%	Ded / \$150 / 20%	Ded / \$150 / 20%	Ded / \$150 / 20%	Ded / \$150 / 20%
Teladoc	\$0 co-pay*	\$0 co-pay*	\$0 co-pay*	\$0 co-pay*	\$0 co-pay*	\$0 co-pay*	\$0 co-pay*
Urgent Care	\$20 co-pay*	\$30 co-pay*	\$30 co-pay*	\$35 co-pay*	\$35 co-pay*	\$30 co-pay*	\$75 co-pay*

* Deductible is waived on these items

Prescription Drugs included with all plans
Annual Rx Deductible \$25 per person (separate from Medical plan deductible, does apply to your medical out of pocket max) 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%
Prescription Plan under Voyager 5000-CAT : Annual Deductible \$500 / Retail 30 day supply - Tier 1 : \$15 co-pay / Tier 2 : \$30 co-pay / Tier 3 : \$50 co-pay / Tier 4 (Specialty Drugs) 50%
Chiropractic manipulations and Acupuncture
In Network Annual Benefit 20 Chiropractic visits / 12 Acupuncture visits Services subject to the standard office visit co-payments, Out of Network Services are subject to deductible then coinsurance -
Vision
Vision Exam - all ages - \$25 copay (1 per 24 months) Vision Hardware (Frames & Lenses or Contacts) - 19 and Older - Covered up to \$300 (1 per 24 months)- 18 and Younger - covered 100%
Dental
Option 1 - Dental Choice Plus Annual Benefit \$1000 - Class I - 0%, Class II - 20%, Class III, - 50% \$50 Deductible applies to Class II & III services, Orthodontia \$1000 Lifetime Benefit Max per person
Option 2 - Dental Choice Plus Annual Benefit \$1500 - Class I - 0%, Class II - 20%, Class III, - 50% \$50 Deductible applies to Class II & III services, \$1000 Lifetime Benefit Max per person
Option 3 - Dental Choice Plus Annual Benefit \$2500 - Class I - 0%, Class II - 20%, Class III, - 50% \$50 Deductible applies to Class II & III services, Orthodontia \$1500 Lifetime Benefit Max per person
<i>Note: This document is for illustration purposes only. Full plan summaries, including out of network benefits available on request.</i>

PACIFICSOURCE NETWORK PROVIDER SEARCH INSTRUCTIONS

Provider search link: <https://pacificsource.com/find-a-doctor>

Step 1 – Click on Find a Doctor Step 2 – Click on skip this step Step 3 – Select Plan year – 2022

Step 4 – Add city, state or zip code area Step 5 – Choose distance

Step 6 – Select Plan or Network – Voyager or Navigator Scroll to bottom and hit provider search.

Or we can do a search for you with a range of miles and send you the complete results.