Western Grocer Employee Benefits Trust

Summary of Plan Options Effective 01.01.2021

Idaho Options

PacificSource Plan Name	Voyager 1000+30-40_20 S2	Voyager 3000+40_30 S2	Voyager 5000+40_30 S2	Voyager 6500+40_30 S2	Voyager HSA 3000_20+Rx S2	Voyager HSA 4500+Rx S2
	In Network	In Network	In Network	In Network	In Network	In Network
Deductible	$1000 per person $1,000 per family	$3,000 per person $6,000 per family	$5,000 per person $10,000 per family	$6,500 per person $13,000 per family	$3,000 per person $6,000 per family	$4,500 per person $9,000 per family
Out-of-Pocket Maximum	$5,000 per person $10,000 per family	$7,100 per person $14,200 per family	$7,100 per person $14,200 per family	$8,000 per person $16,000 per family	$6,750 per person $13,500 per family	$4,500 per person $9,000 per family
Preventive Care						
Well-Baby Care	0% deductible waived	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	0% deductible waived
Routine Gynecological Exams	0% deductible waived	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	0% deductible waived
Professional Services						
Office Visits (PCP/Specialists)	$30 / $40 co-pay*	$40 co-pay*	$40 co-pay*	$40 co-pay*	after deductible, 20%	after deductible, 0%
Teladoc	$10 co-pay*	$10 co-pay*	$10 co-pay*	$10 co-pay*	after deductible, 20%	after deductible, 0%
Urgent Care	$30 co-pay*	$40 co-pay*	$40 co-pay*	$40 co-pay*	after deductible, 20%	after deductible, 0%
Surgery	after deductible, 20%	after deductible, 30%	after deductible, 30%	after deductible, 30%	after deductible, 20%	after deductible, 0%
Hospital Services						
Inpatient Hospital	after deductible, $500 plus 20%	after deductible, $500 plus 30%	after deductible, $500 plus 30%	after deductible, $500 plus 30%	after deductible, 20%	after deductible, 0%
Inpatient Rehabilitative Care	after deductible, $500 plus 20%	after deductible, $500 plus 30%	after deductible, $500 plus 30%	after deductible, $500 plus 30%	after deductible, 20%	after deductible, 20%
Skilled Nursing Facility Care	after deductible, 20%	after deductible, 30%	after deductible, 30%	after deductible, 30%	after deductible, 20%	after deductible, 20%
Outpatient Services						
Outpatient Surgery	after deductible, 20%	after deductible, 30%	after deductible, 30%	after deductible, 30%	after deductible, 20%	after deductible, 0%
CT Scans/MRIs	after deductible, $200 plus 20%	after deductible, $200 plus 30%	after deductible, $200 plus 30%	after deductible, $200 plus 30%	after deductible, 20%	after deductible, 0%
Diagnostic, Lab	after deductible, 20%	after deductible, 30%	after deductible, 30%	after deductible, 30%	after deductible, 20%	after deductible, 0%
Emergency Room Visits	after deductible, $75 plus 20%	after deductible, $100 plus 30%	after deductible, $100 plus 30%	after deductible, $100 plus 30%	after deductible, 20%	after deductible, 0%
Mental Health/Chemical Dependency						
Office Visits	$20 co-pay*	$40 co-pay*	$40 co-pay*	$40 co-pay*	after deductible, 20%	after deductible, 0%
Inpatient Care	after deductible, $500 plus 20%	after deductible, $500 plus 30%	after deductible, $500 plus 30%	after deductible, $500 plus 30%	after deductible, 20%	after deductible, 0%
Residential Programs	after deductible, $500 plus 20%	after deductible, $500 plus 30%	after deductible, $500 plus 30%	after deductible, $500 plus 30%	after deductible, 20%	after deductible, 0%
Other Covered Services						
Rehabilitation & Habilitation Services (PT)	after deductible, 20%	after deductible, 30%	after deductible, 30%	after deductible, 30%	after deductible, 20%	after deductible, 0%
Allergy Injections	$5 copay*	$5 copay*	$5 copay*	$5 copay*	after deductible, 20%	after deductible, 0%
Ambulance, Ground	after deductible 20%	after deductible 30%	after deductible 30%	after deductible 30%	after deductible, 20%	after deductible, 0%
Ambulance, Air	after deductible 20%	after deductible 30%	after deductible 30%	after deductible 30%	after deductible, 20%	after deductible, 0%
Durable Medical Equipment	after deductible 20%	after deductible 30%	after deductible 30%	after deductible 30%	after deductible, 20%	after deductible, 0%
Home Health Care	after deductible 20%	after deductible 30%	after deductible 30%	after deductible 30%	after deductible, 20%	after deductible, 0%
Prescription Drugs						
	Option 1 - ID 5-35-75 25D S2 IDL (Formulary is Idaho Drug List) - 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% **Option 2 - ID 15-30P-50P 500D S2 IDL** (Formulary is Idaho Drug List) - Includes PacificSource Expanded No Cost Drug List (Deductible is waived) After Rx Deductible $500 per person (separate from Medical plan deductible, does apply to your medical out of pocket max) Retail 30 day supply - Tier 1 : $15 co-pay / Tier 2 : 30% / Tier 3 : 50% / Tier 4 (Specialty Drugs) 50%				**ID 20P 3000D S2 IDL** (Formulary is Idaho Drug List) Includes PacificSource Expanded No Cost Drug List (Deductible is waived) After Deductible (Medical & Rx Deductible are combined and applies to the out of pocket max) Retail 30 day supply - Tier 1/Tier 2/Tier 3/Tier 4 : Aftern Deductible 20%	**ID 4500D S2 IDL** (Formulary is Idaho Drug List) Includes PacificSource Expanded No Cost Drug List (Deductible is waived) After Deductible (Medical & Rx Deductible are combined and applies to the out of pocket max) Retail 30 day supply - Tier 1/Tier 2/Tier 3/Tier 4 : Aftern Deductible 0%
Accident Coverage						
	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.