Western Grocer Employee Benefits Trust

Summary of Plan Options Effective 01.01.2022 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
	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
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
Preventive Care				
Well-Baby Care	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
Routine Gynecological Exams	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
Professional Services				
Office Visits (PCP/Specialists)	$30 / $50 co-pay*	$40 co-pay*	$40 co-pay*	$40 co-pay*
Teladoc	$0 co-pay*	$0 co-pay*	$0 co-pay*	$0 co-pay*
Urgent Care	$30 co-pay*	$40 co-pay*	$40 co-pay*	$40 co-pay*
Surgery	after deductible, 20%	after deductible, 30%	after deductible, 30%	after deductible, 30%
Hospital Services				
Inpatient Hospital	after deductible, 20%	after deductible, 30%	after deductible, 30%	after deductible, 30%
Inpatient Rehabilitative Care	after deductible, 20%	after deductible, 30%	after deductible, 30%	after deductible, 30%
Skilled Nursing Facility Care	after deductible, 20%	after deductible, 30%	after deductible, 30%	after deductible, 30%
Outpatient Services				
Outpatient Surgery	after deductible, 20%	after deductible, 30%	after deductible, 30%	after deductible, 30%
CT Scans/MRIs	after deductible, 20%	after deductible, 30%	after deductible, 30%	after deductible, 30%
Diagnostic, Lab	after deductible, 20%	after deductible, 30%	after deductible, 30%	after deductible, 30%
Emergency Room Visits	after deductible, $200 plus 20%	after deductible, $200 plus 30%	after deductible, $200 plus 30%	after deductible, $200 plus 30%
Mental Health/Chemical Dependency				
Office Visits	$20 co-pay*	$40 co-pay*	$40 co-pay*	$40 co-pay*
Inpatient Care	after deductible, 20%	after deductible, 30%	after deductible, 30%	after deductible, 30%
Residential Programs	after deductible, 20%	after deductible, 30%	after deductible, 30%	after deductible, 30%
Other Covered Services				
Rehabilitation & Habilitation Services (PT)	after deductible, 20%	after deductible, 30%	after deductible, 30%	after deductible, 30%
Allergy Injections	$5 copay*	$5 copay*	$5 copay*	$5 copay*
Ambulance, Ground	after deductible 20%	after deductible 30%	after deductible 30%	after deductible 30%
Ambulance, Air	after deductible 20%	after deductible 30%	after deductible 30%	after deductible 30%
Durable Medical Equipment	after deductible 20%	after deductible 30%	after deductible 30%	after deductible 30%
Home Health Care	after deductible 20%	after deductible 30%	after deductible 30%	after deductible 30%
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%			
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			
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			
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 Benefi **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 Benefi **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 Benefi			

** 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.

PacificSource HEALTH PLANS

Voyager HSA 3000_20+Rx S2	Voyager HSA 4500+Rx S2
In Network	**In Network**
$3,000 per person $6,000 per family	$4,500 per person $9,000 per family
$6,750 per person $13,500 per family	$4,500 per person $9,000 per family
0% deductible waived	0% deductible waived
0% deductible waived	0% deductible waived
0% deductible waived	0% deductible waived
0% deductible waived	0% deductible waived
after deductible, 20%	after deductible, 0%
after deductible, 20%	after deductible, 0%
after deductible, 20%	after deductible, 0%
after deductible, 20%	after deductible, 0%
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after deductible, 20%	after deductible, 0%
after deductible, 20%	after deductible, 0%
after deductible, 20%	after deductible, 0%
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 -	**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 - After Deductible 0%

enrolled in this plan. The balance is covered by the plan.

4 months)

it Max per person

it Max per person

it Max per person