
 The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, see <https://benefits.wincofoods.com/>. For definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/glossary/> or call 1-866-240-9580 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall <u>deductible</u>?	In-network: \$150 individual / \$450 family medical coverage. Out-of-network: \$300 individual / \$900 family medical coverage.	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .	For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	In-network: medical \$1,150 individual / \$3,450 family; prescription \$7,950 individual / \$14,750 family. Out-of-network: medical \$2,300/individual.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. You have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limit</u> , until the overall family <u>out-of-pocket limit</u> , has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See regence.com or call 1-866-240-9580 for a list of <u>network providers</u> .	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see a <u>specialist</u> without permission or a <u>referral</u> .

* For more information about limitations and exceptions, see the plan or policy document at <https://benefits.wincofoods.com>

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Blank cell Common Medical Event	Services You May Need	What You Will Pay:		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Spinal manipulations limited to 20/year.
	<u>Preventive care/screening/immunization</u>	No charge	30% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	May require <u>prior authorization</u> .
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	May require <u>prior authorization</u> .
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at https://benefits.wincofoods.com/	Generic drugs	Retail: 15% <u>coinsurance</u> , \$5 minimum retail. Mail order: \$5 <u>copay</u> 30 day supply, \$10 <u>copay</u> over 30 day supply.	Full drug cost; can submit reimbursement for calculated cost.	May require <u>prior authorization</u> . Covers up to a 90 day supply.
	Preferred brand drugs	Retail: 20% <u>coinsurance</u> , \$5 minimum retail. Mail order: \$15 <u>copay</u> 30 day supply, \$30 <u>copay</u> over 30 day supply.	Full drug cost; can submit reimbursement for calculated cost.	May require <u>prior authorization</u> . Covers up to a 90 day supply.
	Non-preferred brand drugs	Retail: 35% <u>coinsurance</u> , \$5 minimum retail, Mail order: \$25 <u>copay</u> 30 day supply, \$50 <u>copay</u> over 30 day supply.	Full drug cost; can submit reimbursement for calculated cost.	May require <u>prior authorization</u> . Covers up to a 90 day supply.
	<u>Specialty drugs</u>	Mail order: \$50 <u>copay</u> or actual cost whatever is less	Full drug cost; can submit reimbursement for calculated cost.	May require a <u>prior authorization</u> . Covers up to a 30 day supply mail order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u> ambulatory surgery center 20% <u>coinsurance</u> all other	30% <u>coinsurance</u>	May require <u>prior authorization</u> .
	Physician/surgeon fees	10% <u>coinsurance</u> ambulatory surgery center 20% <u>coinsurance</u> all other	30% <u>coinsurance</u>	May require <u>prior authorization</u> .

* For more information about limitations and exceptions, see the plan or policy document at <https://benefits.wincofoods.com>

Common Medical Event	Services You May Need	What You Will Pay:		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>In-network deductible</u> applies to <u>in-network</u> and out-of- <u>network</u> services.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	If member not transported after emergency service is called, ambulance service not covered under the <u>plan</u> .
	<u>Urgent care</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you are pregnant	Office visits	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 60 visits/year.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 22 inpatient days/year. Limited to 50 outpatient visits/year for physical therapy, occupational therapy and speech therapy services.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Includes physical therapy, occupational therapy and speech therapy services. Neurodevelopment therapy limited to 52 visits/year.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 60 inpatient visits/year.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	<u>Hospice services</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Respite care limited to 14 days/lifetime.

Excluded Services & Other Covered Services

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- | | | |
|---|--|---|
| <ul style="list-style-type: none">• Acupuncture, rolfing, massage therapy or hypnosis• Cosmetic surgery, except congenital anomalies• Dental care, covered by dental plan | <ul style="list-style-type: none">• Hearing aids• Infertility treatment• Long-term care• Private-duty nursing | <ul style="list-style-type: none">• Routine eye care, covered by vision plan• Routine foot care• Vision hardware, covered by vision plan• Weight loss programs |
|---|--|---|

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- | | | |
|---|---|--|
| <ul style="list-style-type: none">• Bariatric Surgery | <ul style="list-style-type: none">• Chiropractic Care | <ul style="list-style-type: none">• Non-emergency care when traveling outside the U.S. |
|---|---|--|

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the plan at 1 (866) 240-9580. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the plan at 1 (866) 240-9580 or visit regence.com or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or www.dol.gov/ebsa/healthreform. You may also contact the Idaho Department of Insurance by calling 1 (208) 334-4250 or www.doi.idaho.gov.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services: Spanish (Español): <https://benefits.wincofoods.com>

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1146. The time required to complete this information collection is estimated to average 0.08 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

About these Coverage Examples



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery. Cost for the baby not included.)

- The plan's overall deductible \$150
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$150
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1000

<i>What isn't covered</i>	
Limits or exclusions	\$96
The total Peg would pay is	\$1,246

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$150
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs (*mail order*)
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$150
<u>Copayments</u>	\$430
<u>Coinsurance</u>	\$980

<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,560

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$150
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$150
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$530

<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$680

[The plan would be responsible for the other costs of these EXAMPLE covered services.]