SUMMARY OF MATERIAL MODIFICATIONS
To the Summary Plan Description (SPD) of the
WinCo Foods Employee Benefit Plan

This Summary of Material Modifications (SMM) is to inform you of updates to the WinCo Foods Employee Benefit Plan (the Plan) as explained in the Plan Document and Summary Plan Description (SPD). These updates are effective Jan. 1, 2023.

These updates should be added to your current SPD book. (Please note that these updates and page numbers reference the 2022 SPD book, Jan. 1, 2022 version.) Please keep this copy for your reference.

To review and download the most current electronic copy of the Plan Document and Summary Plan Description (SPD), go to benefits.wincofoods.com/. Or, if you are actively covered by WinCo Holdings, Inc.'s (WinCo) health insurance, you can request a new copy from Benefits at benefits@wincofoods.com.

Plan Information and Contract Administrators

Section 4 – Enrollment

Page 15, Deadline Relief for Health Plan Participants under DOL EBSA Notice 2021-01
In accordance with Department of Labor and other regulatory agency guidelines, the following deadlines listed in the SPD are suspended during the "Outbreak Period," which began on March 1, 2020 and is anticipated to last through March 1, 2023, unless congressional or presidential action terminate the emergency earlier. The deadline relief allows for a longer period than normal to add dependents to benefits; request appeals; and elect and make initial payment for COBRA coverage. However, note that under DOL guidance, an individual's deadline relief cannot apply for more than one year; this means depending on your life event date, your deadline relief period may have already expired. For more information, please contact Benefits at 1-800-341-6543.

- The 30-day (or, if applicable the 60-day) period to request a HIPAA special enrollment (such as adding a newborn or newly adopted child, or adding a spouse)
- The 60-day period to elect COBRA coverage
- The due date for COBRA premium payments
- The date a COBRA qualified beneficiary must provide notice of a qualifying event or a disability determination
- The date a claimant is required to file a claim for plan benefits
- The date the claimant is required to file an appeal of an adverse determination of a claim for benefits
- The date by which a claimant is required to file a request for an external review

Section 9 – Medical

Page 23, Calendar Year Deductible: revised – Individual/Family: In-network: $150/$450; Non-network: $300/$900.

Page 23, Dialysis: Dialysis services will be processed as in-network in instances where the provider has entered into an agreement with WinCo, in which case, claims will be processed per the terms of the particular agreement. All other dialysis services will be processed as out-of-network and paid based on UCR.

Page 23, Medical Out-of-Pocket Maximum: revised – Individual/Family: In-network: $1,150/$3,450; Non-network: $2,300/No maximum.

Page 24, Skilled Nursing Facility (Limited to 60 days per Participant, per Calendar Year). Changed from 30 to 60 days.

Section 11 – Medical – Benefits

Page, 27, 11.3 Deductible: revised -

A. Individual - A Participant's individual In Network Deductible consists of the first $150 in eligible benefits for major medical Covered Services per Calendar Year. The individual deductible for Non Network services is $300.
B. Family - The aggregate of the first $450 in eligible benefits for major medical Covered Services per Calendar Year for all Participants enrolled under the same family coverage shall be the Deductible. However, no Participant may be required to pay more than the Individual Deductible amount. The family deductible for Non Network services is $900.
C. Preventive Care - The Deductible does not apply to Covered Services for listed routine immunizations or preventive care as defined by the Affordable Care Act.

Page 27, 11.5.1 In-network Services, first paragraph: revised – The medical Out-of-pocket Maximum is $1,150 per Participant and the prescription Out-of-pocket Maximum is $7,950 per Participant, per Calendar Year. The medical family Out-of-Pocket maximum is $3,450 per Calendar Year and the prescription family Out-of-Pocket Maximum is $14,750 per Calendar Year. If any Participant reaches the individual Out-of-Pocket Maximum then the Out-of-Pocket Maximum is satisfied for that Participant. If any combination of family members reach the family out-of-pocket maximum, then the out-of-pocket maximum is satisfied for the entire family.

11.5.2 Out-of-network Services: revised - The medical Out-of-pocket Maximum shall be $2,300 per Participant, per Calendar Year. There is no family maximum. When a Participant has met the medical Out-of-pocket Maximum, the benefits payable on behalf of the Participant for Out-of-network Covered Services shall increase to 100% of the Maximum Allowance during the remainder of the Calendar Year.

11.9.5 Maternity Services: Deleted "No benefits are provided for any normal pregnancy, complications of pregnancy whether voluntary or involuntary or abortion for any reason, for enrolled eligible Dependent children."

Section 15 – Prescription

Page 48, 15.1 Prescription Benefits & Coverages table: Added asterisks next to "$5 minimum" in the Retail column and added an asterisked statement "*Member shall pay the lesser of the submitted charge by the pharmacy, or the applicable Coinsurance as reflected in the Prescription Benefits & Coverages table in Section 15.1 of the SPD." This was already how retail claims were administered; note added for clarity.

Page 48, 15.1 Added the following language - Variable Copay Program (VCP): Many medications (usually Specialty Drugs) have manufacturer programs which financially assist patients in the purchase of their medications. Under the Variable Copay Program (VCP), the member's out-of-pocket cost for qualifying medications and the cost to the Plan may be changed in such a way to utilize a manufacturer's copay subsidy. If you are eligible to receive a manufacturer copay subsidy, you will be contacted by the pharmacy benefit manager to assist you in enrolling in the VCP. Once in the VCP, your copay obligation will be adjusted to the maximum manufacturer copay subsidy for that medication in order to maximize manufacturer rebates to both the member and the Plan. If your medication is ineligible for a manufacturer copay subsidy, your copay obligation will be the standard copay amount as listed in the summary plan description. Please note, only actual out-of-pocket payments will count toward your annual out-of-pocket maximum. Also, 90 day supplies are not available for medications eligible for the VCP."

Page 48, 15.3 Tiered Benefits, first paragraph: revised – There are tiers (or levels) of covered prescriptions. The Coinsurance/Copay applies toward individual prescription out of pocket maximum of $7,950 or family out of pocket maximum of $14,750.

Section 16 – Dental

Page 51, 16.1 Dental Benefits & Coverages (table): Added "Preventive and diagnostic services are excluded from the annual maximum."

Section 20 – Group Term Life

Page 57, 20.2 Eligibility: The Employee must be considered an active employee at time of death and satisfy any eligibility criteria as described in the current Insurance Certificate.

Page 57, 20.3 When Insurance Begins: Changed statement about eligibility requirements from 12 to 5 or more hours per week.

Section 21 – Cafeteria Plan – Flexible Benefits Plan Introduction

Page 63, 21.5.4 Limitation on Allocations: revised - A. Notwithstanding any provision contained in this Health Care Flexible Spending Arrangement to the contrary, the maximum amount that may be allocated to the Health Care Flexible Spending Arrangement by a Participant in or on account of any Plan Year is $2,850.

Section 22 – Other Benefits

Page 74 22.1.2 Benefits – Changed from three (3) face-to-face sessions with a counselor (per person per Calendar Year to five (5) face-to-face sessions with a counselor (per person per Calendar Year).

Section 26 - Definitions

Page 87 Deductible – Changed references from $100 to $150