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 deductible?	In-network: $175 individual / $525 family medical coverage. Out-of-network: $350 individual / $1,050 family medical coverage.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for	No.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-network: medical $1,175 individual / $3,525 family; prescription $7,275 individual / $13,375 family; emergency room $1,000 individual / $2,000 family. Out-of-network: medical $2,350/individual; emergency room $1,000 individual / $2,000 family.	The out-of-pocket limit is the most you could pay in a year for covered services. You have other family members in this plan, they have to meet their own out-of-pocket limit, until the overall family out-of-pocket limit, has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See regence.com or call 1-866-240-9580 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before
Do you need a referral to see a specialist?	No.	You can see a specialist without permission or a referral.

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

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022) (HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

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

* 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: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	$50 per visit copay + deductible + 20% coinsurance	$50 per visit copay + deductible + 20% coinsurance	In-network deductible applies to in-network and out-of-network services.
	Emergency medical transportation	20% coinsurance	20% coinsurance	If member not transported after emergency service is called, ambulance service not covered under the plan.
	Urgent care	20% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee	20% coinsurance	30% coinsurance	None
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	30% coinsurance	None
	Inpatient services	20% coinsurance	30% coinsurance	None
If you are pregnant	Office visits	20% coinsurance	30% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC.
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	Limited to 60 visits/year.
	Rehabilitation services	20% coinsurance	30% coinsurance	Limited to 22 inpatient days/year. Limited to 50 outpatient visits/year for physical therapy, occupational therapy, and speech therapy services.
	Habilitation services	20% coinsurance	30% coinsurance	Includes physical therapy, occupational therapy, and speech therapy services. Neurodevelopment therapy limited to 52 visits/year.
	Skilled nursing care	20% coinsurance	30% coinsurance	Limited to 60 inpatient visits/year.
	Durable medical equipment	20% coinsurance	30% coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	20% coinsurance	30% coinsurance	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.)		
• Acupuncture, rolfing, massage therapy or hypnosis • Cosmetic surgery, except congenital anomalies • Dental care, covered by dental plan	• Hearing aids • Infertility treatment • Long-term care • Private-duty nursing	• 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.)		
• Bariatric Surgery	• Chiropractic Care	• 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.

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	$175
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:

Cost Sharing	
Deductibles	$175
Copayments	$0
Coinsurance	$1000
What isn't covered	
Limits or exclusions	$96
The total Peg would pay is	**$1,271**

Managing Joe's Type 2 Diabetes

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

The plan's overall deductible	$175
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:

Cost Sharing	
Deductibles	$175
Copayments	$430
Coinsurance	$980
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,585**

Mia's Simple Fracture

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

The plan's overall deductible	$175
Specialist coinsurance	20%
ER copay	$50
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:

Cost Sharing	
Deductibles	$175
Copayments	$50
Coinsurance	$530
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$755**

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