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, https://benefits.wincofoods.com/. For general 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 1-800-937-8063 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 specific services?	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: $8,425 individual / $15,675 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. If 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. Each emergency room copayment applies to the separate emergency room out-of-pocket maximum. Other emergency room services apply to the medical deductible and medical out-of-pocket maximum.
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 https://www.bcidaho.com/ or call 1-800-937-8063 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

Important Questions	Answers	Why This Matters:
		you get services.
Do you need a referral to see a specialist?	No.	You can see a specialist without permission or a referral.

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

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% 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. No charge In-Network for one supplemental breast cancer screening if you have a heightened risk of cancer.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance	Does not require prior authorization.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	Does not require prior authorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://welldyne.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. ***MANDATORY GENERIC REQUIREMENT (see Important Information)**	Full drug cost; can submit reimbursement for calculated cost.	May require prior authorization. Covers up to a 90 day supply. IMPORTANT: **Plan requires use of generics where available. If you fill a brand name medication where generic is available, you will pay the brand copay PLUS the cost difference between the generic and brand medication.**
	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	Full drug cost; can	May require a prior authorization. Covers

[* 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)	
		cost whatever is less	submit reimbursement for calculated cost.	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.
If you need immediate medical attention	Emergency room (ER) care	*$100 per visit copay + deductible + 20% coinsurance *$100 copay is like a **surcharge** for using ER services; see important information for details.	*$100 per visit copay + deductible + 20% coinsurance	In-network deductible applies to in-network and out-of-network services. The ER copay has a separate out of pocket maximum: $1,000 per individual/$2,000 per family. Other ER charges apply toward the **medical** deductible & out-of-pocket maximum.
	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 (e.g., hospital room)	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

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)	
				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 days/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.
If your child needs dental or eye care	Children's eye exam	$10 copay	Only up to $45 is reimbursed.	
	Children's glasses	$150 allowance, every 12 months	Only up to $70 is reimbursed.	
	Children's dental check-up	0% coinsurance	20% coinsurance	

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 1-800-937-8063. 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 1-800-937-8063 or visit https://www.bcidaho.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.

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

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)

The plan's overall deductible	**$175**
Specialist *[cost sharing]*	**20%**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**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 *[cost sharing]*	**20%**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
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 *[cost sharing]*	**20%**
ER copay	**$100**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**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	$100
Coinsurance	$525
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$800**

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