

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). This document reflects both changes that will occur effective January 1, 2026, as well as changes that were made retroactively effective back to January 1, 2025.

These updates should be added to your current SPD book. (Please note that these updates and page numbers reference the 2025 SPD book, Jan. 1, 2025 version.) Please keep this copy for your reference. On or around January 1, 2026, a restated version of the SPD will be posted at <https://benefits.wincofoods.com>. The restated version will incorporate the additions and deletions noted in this document.

To review and download the most current electronic copy of the Plan Document and Summary Plan Description (SPD), go to <https://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.

THE FOLLOWING CHANGES ARE EFFECTIVE JANUARY 1, 2026 UNLESS OTHERWISE NOTED

Section 9 - Medical

Page 23, Section 9.1 Edited text to reflect Emergency Room Copayment increase to \$100 per visit and out-of-pocket maximum increase to \$1,000 and \$2,000 for individual and family coverage, respectively.

Emergency Room Copayment Out-of-pocket Maximum			
Individual (ER only) *		<u>\$1,000*</u>	\$1,000
Family (ER only) *		<u>\$2,000*</u>	\$2,000
Emergency Room (<u>\$100.00</u> copay required per visit + deductible/coinsurance) <i>Payment for Out-of-Network Emergency Services is based on the Qualifying Payment Amount.</i>	Yes	20% Coinsurance	20% Coinsurance

Page 23, Section 9.1 Added a new row to the Medical Benefits & Coverages table describing our new-for-2026 Supplemental Breast Cancer Screening benefit available to members at a heightened risk of breast cancer.

Medical Benefits & Coverages		Participating In-network Providers	Non-Participating Out-of-network Providers
COVERED SERVICES	In-network Deductible and/or Coinsurance payment required before insurance pays?	In-network	Out-of-network
By choosing an Out-of-network Provider, the Participant may be responsible for the difference between the Allowed Amount and what the Out-of-network Provider charges. Some services may require Pre-authorization.			
<u>**Supplemental Breast Screening</u> <i>(For Participants at heightened risk of breast cancer. Includes breast exam using standard or abbreviated MRI, contrast mammogram imaging, or ultrasound.) One supplemental breast screening per Participant, per Calendar Year, combined In-network and Out-of-network. For additional exams, Diagnostic or Preventive Care Services apply as listed in the Medical Benefits & Coverages table.</i>	<u>No</u>	<u>0%</u>	<u>Deductible & Coinsurance (30%)</u>

Below the table, the following text:

****Benefits are provided for One (1) Supplemental Breast Screening per Benefit Period for a Participant at Heightened Risk of Breast Cancer. For purposes of this coverage, a "Supplemental Breast Screening" means a Medically Necessary and clinically appropriate examination of the breast using either standard or abbreviated magnetic resonance imaging, contrast mammogram imaging, or, if such imaging is not possible, ultrasound when there is no abnormality seen or suspected in the breast. In addition, a "Heightened**

Risk of Breast Cancer” means the Participant is believed to be at an increased risk of breast cancer due to personal history of atypical breast histologies, personal history, or family history of breast cancer, genetic predisposition for breast cancer, prior therapeutic thoracic radiation therapy, lifetime risk of breast cancer of twenty percent (20%) or more according to risk assessment tools based on family history, extremely dense breast tissue based on breast composition categories, or heterogeneous dense breast tissue base on breast composition categories in combination with recognized risk factor.

Section 11 – Medical - Benefits

Page 28, Section 11.5.3 Edited the following underlined text.

“Emergency Room services feature a \$100 per-visit copay and an out-of-pocket maximum of \$1,000 per Participant, per Calendar Year. The Emergency Room family Out-of-pocket maximum is \$2,000 per Calendar Year. Other ER services apply to the medical deductible and medical out-of-pocket maximum.

Page 31, Section 11.9.3 Replaced entire section with the following text:

D. Ambulance Transportation Service

Ambulance transportation services are covered for Medically Necessary transportation of a Participant as follows:

1. Emergency Ground Ambulance transportation services when all of the following criteria are met:
 - a. The medical transport services comply with all applicable laws and must have all the appropriate, valid licenses and permits,
 - b. The ambulance or other medical transport services must have the necessary patient care equipment and supplies,
 - c. The Participant’s condition must be such that any other form of transportation would be medically contraindicated, and
 - d. The Participant must be transported to the nearest hospital with the appropriate facilities for the treatment of the Participant’s Illness or Injury or, in the case of organ transplantation, to the approved transplant facility, unless the nearest appropriate hospital is on divert or has no available beds or accepting Physician. Consideration can be made to allow a Participant to remain within a specific hospital network.
2. Emergency Air Ambulance transportation services from the site of accident, Injury or Illness, provided:
 - a. All of the above criteria for Emergency Ground Ambulance transportation services are met, and
 - b. The Participant is in critical condition and/or has unstable vital signs, respiratory status or cardiac status, and either:
 - i. The point of pick-up is inaccessible by land vehicle, or Ground Ambulance transportation is precluded due to adverse weather and/or road conditions (e.g., flooding, ice, or snow), or
 - ii. Transportation by Ground Ambulance poses a threat to the Participant’s survival or seriously endangers the Participant’s health due to the time, distance, or instability of

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transportation by ground. Generally, the time and distance requirements are met if the total estimated time for transportation from the site of accident, injury, or illness is projected to be at least thirty (30) minutes shorter for Air Ambulance than for Ground Ambulance.

3. Emergency Air Ambulance transportation services from a health care Facility, hospital emergency department, or Inpatient setting, when all of the following criteria are met:
 - a. The Participant is in critical condition, has unstable vital signs, unstable respiratory or cardiac status,
 - b. The Participant requires acute medical or surgical intervention(s) that the transferring facility cannot provide,
 - c. The Participant is being transferred to the nearest equivalent or higher level of acuity Inpatient facility unless the nearest appropriate hospital is on divert, has no available beds or accepting Physician, or the Air Ambulance cannot land (except consideration can be made to allow a Participant to remain within a specific hospital network), and
 - d. Transportation by Ground Ambulance poses a threat to the Participant's survival or seriously endangers the Participant's health due to the time, distance, or instability of transportation by ground. Generally, the time and distance requirements are met if the total estimated time for transportation from the originating to the receiving facility is projected to be at least thirty (30) minutes shorter for Air Ambulance than for Ground Ambulance.
4. Ground Ambulance transportation services or Air Ambulance transportation services that are not for an Emergency Medical Condition require Prior Authorization.

As exceptions to the above, ambulance transportation services are considered not Medically Necessary in the following circumstances:

- a. Transportation from a hospital, capable of treating the Participant to another hospital primarily for the convenience of the Participant or Participant's family, Physician, or other health care provider, or because the Participant and/or Participant's family prefer a specified hospital or Physician,
- b. Non-medical transport services such as those provided by medical vans or commercial transportation,
- c. Transportation or transfers to or from (i) a Skilled Nursing Facility (SNF), (ii) physician's office, (iii) any other facilities, and/or (iv) the Participant's home (which includes a private residence or domicile, assisted living facility, or long-term care facility) for any reason including but not limited to outpatient treatment, procedures, or tests,
- d. Transportation of a deceased Participant when the Participant was pronounced dead at the scene,
- e. Transportation to a facility that is not an acute care hospital with appropriate facilities to treat the condition for which the transfer was made,
- f. Transportation related to search and rescue operations, and
- g. Transportation to a facility that is not the closest location capable of providing the level of care required.

Section 12 – Medical – Pre-authorization

Page 41, Section 12.1: Added the following text.

[The following listing includes specific Procedures and Services, as well as a few general categories or examples of Procedures and Services, that require Prior Authorization. In the case of general categories or examples, call Customer Service at the phone number listed on the back of the Participant's Identification Card to confirm if a specific Procedure or Service requires Prior Authorization.](#)

Page 42, Section 12.1 Added the following items to the list of services requiring medical preauthorization:

[Musculoskeletal procedures for spine and joints](#) (effective November 2025)

[Pain management](#) (effective November 2025)

Section 14 – Exclusions and Limitations

Page 49, Section 14.1 Deleted reference to homeopathic and naturopathic providers in the exclusions listing.

AC. For Acute Care, rehabilitative care, or diagnostic testing, except as specified as a Covered Service in the Plan; for mental or nervous conditions and substance abuse or addiction services not recognized by the American Psychiatric and American Psychological Association; For relaxation or exercise therapies, including but not limited to, educational, art, aroma, dance, sex, sleep, electro sleep, vitamin, chelation, [homeopathic, or naturopathic](#), massage, or music even if prescribed by a Physician. Recreational therapy or therapeutic recreation programs, which can include, but are not limited to, diabetes camps, adventure therapy, and/or wilderness therapy (which can include, but are not limited to, programs for outdoor behavioral health, childhood diabetes, and childhood cancer).

Section 15 – Prescription Drugs

EFFECTIVE NOVEMBER 15, 2025 - Page 53, Section 15.2: Added the text “unless generic is available” to describe our mandatory generics program.

Prescription Benefits & Coverages	Retail	Mail Order	Mail Order 90 Day Brand Name Only
Generic Drugs (Tier 1) Covers up to a 90 day supply.	15% Coinsurance, \$5 minimum*	\$5 Copay for 30 day supply, \$10 Copay for over 30 day supply	N/A
Preferred Brand Drugs (Tier 2) Covers up to a 90 day supply.	20% Coinsurance, \$5 minimum* (unless generic is available**)	\$15 Copay for 30 day supply, \$30 Copay for over 30 day supply (unless generic is available**)	\$0 Copay Limited formulary
Non-preferred Brand Drugs (Tier 3) May require Prior Authorization; covers up to a 90 day supply.	35% Coinsurance, \$5 minimum* (unless generic is available**)	\$25 Copay for 30 day supply, \$50 Copay for over 30 day supply (unless generic is available**)	\$0 Copay Limited formulary
Specialty Drugs (Tier 4) May require Prior Authorization; covers up to a 30 day supply mail order.	N/A	\$50 Copay or actual cost whatever is less (unless generic is available**)	\$0 Copay Limited formulary

* 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. **[Effective November 15, 2025, members who fill a brand-name medication when a generic alternative is available will be subject to paying the brand coinsurance/copay PLUS the cost difference between the brand and generic medication \(unless an appeal is approved by the Plan.\)](#)

Page 53, Section 15.2: For the 2026 Plan year, edited following text. Effective January 1, 2026.

The Prescription Drug Out-of-pocket Maximum is [\\$8,425](#) per Participant, per Calendar Year. The Prescription Drug family Out-of-pocket Maximum is [\\$15,675](#) per Calendar Year.

For the remainder of section 15, updated the numbering on all subpoints to accommodate for section 15.2 being inserted.

Section 26 – Definitions

Page 98, Maximum Allowance definition. Inserted the following text:

“Notwithstanding, if the Contract Administrator has agreed to pay a Contracting Provider an amount for hospital Inpatient or Outpatient services that is higher than the Provider’s billed charge, the Maximum Allowance is the allowance set forth in the Provider contract.”

THE FOLLOWING CHANGES WERE EFFECTIVE JANUARY 1, 2025, AND WERE INCORPORATED INTO THE 2025 SPD

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Page 2, Under *Contract Administrator Medical*: Deleted the phrase “Verbal requests can be made by calling 888-494-2583.” Reason: All appeals must be written.

Section 9 - Medical

Page 23, Section 9.1 Added the following underlined text: Emergency Room Copayment Out-of-pocket Maximum. Edited the 2025 Out-of-pocket maximum for in-network providers to \$750 for individual and \$1,500 for family coverage; this amount was reduced for the 2025 plan year only.

Page 23, Section 9.1 Added the underlined text (below) regarding Bariatric Surgical Services to signify that they are only covered at Blue Distinction Centers.

Medical Benefits & Coverages		Participating In-network Providers	Non-Participating Out-of-network Providers
COVERED SERVICES <i>By choosing an Out-of-network Provider, the Participant may be responsible for the difference between the Allowed Amount and what the Out-of-network Provider charges. Some services may require Pre-authorization.</i>	In-network Deductible and/or Coinsurance payment required before insurance pays?	In-network	Out-of-network
<u>Bariatric Surgical Services</u> <u>(Limited to one Surgery per lifetime. Surgical services must be performed at a Blue Distinction Center. Please see section 11.9.21 for additional requirements.)</u>	<u>Yes</u>	<u>20% Coinsurance and only covered when received at a Blue Distinction Center</u>	<u>Not Covered</u>

Section 11 – Medical - Benefits

Page 28, Section 11.5 Added the following underlined text.

The Medical and Emergency Room Out-of-pocket Maximum shall be based upon a Participant’s eligible Out-of-pocket expenses incurred during one Calendar Year.

- B. Prescription Drugs (please see the Prescription Drug section for separate Out-of-Pocket limit);
- E. Amounts that exceed benefit limits.

Page 28, Section 11.5.1 Added or edited the following underlined text. This was effective January 1, 2025.

11.5.1 In-network Services

The medical Out-of-pocket Maximum is \$1,175 per Participant ~~and the prescription Out-of-pocket Maximum is \$7,275 per Participant~~, per Calendar Year. The medical family Out-of-pocket maximum is \$3,525 per Calendar Year ~~and the prescription family Out-of-Pocket Maximum is \$13,375 per Calendar Year~~. Emergency Room professional and facility services apply to the medical Out-of-pocket Maximum. 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.

When a Participant and/or family has met the medical Out-of-pocket Maximum, the benefits payable on behalf of the Participant for In-network Covered Services shall increase to 100% of the Maximum Allowance during the remainder of the Calendar Year. ~~When a Participant and/or family has met the~~

~~prescription Out-of-pocket Maximum, the benefits payable on behalf of the Participant for Covered Services shall increase to 100% of the Maximum Allowance during the remainder of the Calendar Year.~~

Page 28, Section 11.5.3 Added or edited the following underlined text. This was effective January 1, 2025.

11.5.3 Emergency Room Services – Emergency Room services feature a \$50 per-visit copay and an Out-of-pocket maximum of ~~\$1,000~~750 per Participant, per Calendar Year. The Emergency Room family Out-of-pocket maximum is ~~\$2,000~~1,500 per Calendar Year. These amounts are the same regardless of whether an in-network or non-network provider is utilized. Only the Emergency Room Copayment amount applies to the Emergency Room Services Out-of-pocket Limit. Once the Participant and/or family Out-of-pocket limit has been met, no additional copayment is required.

11.9.21 Bariatric Services

Bariatric services will be considered if a Participant meets the definition of obesity as defined by the Contract Administrator's medical policy. Covered treatment includes surgical procedures and non-surgical treatment to correct obesity or for reversals or revisions of Surgery for obesity. Refer to section 14 for treatment that is not covered, even for obesity.

Surgical services are only covered when provided by a Blue Distinction Center and limited to one Surgery per lifetime. The Plan will not cover surgical services designed to improve appearance or remove excess

skin (even if excess skin is caused by weight loss as a result of gastric bypass surgery). If you and/or your doctor would like to learn more about this program or the selection criteria used to evaluate hospitals for designation, visit www.bcbs.com/bluedistinction or contact the Contract Administrator.

Non-surgical services including Office Visits, Office Visits for Pre and Post operative services, Diagnostic services and other related non-surgical covered services are not included in the surgical lifetime limit and are not required to be provided by a Blue Distinction Center.

The Plan will not cover surgeries designed to improve appearance or remove excess skin (even if excess skin is caused by weight loss as a result of gastric bypass surgery). Bariatric services will be considered if a Participant meets the definition of obesity as defined by the Contract Administrator's medical policy. Services are only covered when provided by a Blue Distinction Center and limited to one per lifetime. Contact the Contract Administrator for information.

Covered treatment includes surgical procedures and non-surgical treatment to correct obesity or for reversals or revisions of Surgery for obesity. Refer to the Section 14 for treatment that is not covered, even for obesity. The Plan will not cover surgeries designed to improve appearance or remove excess skin (even if excess skin is caused by weight loss as a result of gastric bypass surgery). A Pre-authorization is required before receiving services.

Section 12 – Medical – Pre-authorization

Page 42, Section 12.1 Added the following items to the list of services requiring medical preauthorization.

[Sleep studies](#)

Bariatric [Surgical](#) services (this was only a slight text edit; original text was: Bariatric Services including surgical and non surgical)

[Certain cardiology procedures and testing](#)

Section 14 – Exclusions and Limitations

Page 52, Section 14.1 Added item BX.

[BX. Any newly FDA approved Prescription Drug, biological agent, or other agent until it has been reviewed and implemented by the Contract Administrator's Pharmacy and Therapeutics Committee and/or Medical Policy Committee.](#)

Section 15 – Exclusions and Limitations

Page 53, Section 15.2: Added the following subpoint and text.

15.2 Prescription Drug Out-of-pocket Maximums

The Prescription Drug Out-of-pocket Maximum is \$7,275 per Participant, per Calendar Year. The Prescription Drug family Out-of-pocket Maximum is \$13,375 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.

When a Participant and/or family has met the prescription Out-of-pocket Maximum, the benefits payable on behalf of the Participant for Covered Services shall increase to 100% of the Maximum Allowance during the remainder of the Calendar Year.

Section 23 – Claims and Appeals

Page 81, Section 23.2.1 Edited to remove language that had formerly allowed for verbal appeals.

23.2.1 Appeals

Appeals can be initiated through ~~either~~ written ~~or verbal~~ request. A written request can be made by sending it to the Contract Administrator. ~~Verbal requests can be made by calling the Contract Administrator.~~

Page 85, Section 23.2.5 Removed the word “verbal.”