GBS
A Leavitt Group Company

Wendy's

Wendy's of Idaho 2020 Employee Benefit Guide

P.O. Box 1766 * 425 N Capital, Suite B * Idaho Falls, ID 83402 * Phone (208) 529-3541

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Classifications

Class III – Hourly Crew

Class II – Hourly Management/Shift Manager

Class I – Owners and Salaried Management

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 the 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, visit https://members.bcidaho.com/my-account/my-account-my-contract.page. 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 www.healthcare.gov/sbc-glossary or call 1-800-627-1188 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall Deductible?	In-Network **$1,500** person/**$3,000** family; Out-of-Network **$4,500** person/**$9,000** family	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. Pharmacy, child vision, immunizations or In-Network hospice, services w/physician Copay and Preventive Care are covered before you meet your Deductible.	This Plan covers some items and services even if you haven't yet met the Deductible amount. But a Copayment or Coinsurance may apply. 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. There are no other specific Deductibles.	You don't have to meet Deductibles for specific services.
What is the Out-of-pocket Limit for this Plan?	In-Network **$5,250** person / **$10,500** family, Out-of-Network **$15,750** person / **$31,500** 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 Limits 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 **www.bcidaho.com or call 1-800-627-1188** for a list of Network Providers.	You pay the least if you use a Provider on the ChoiceDocs In-Network Provider list. You pay more if you use all other Providers on the In-Network Provider list. 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 Providers 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 you get services.
Do you need a Referral to see a Specialist?	No.	You can see the Specialist you choose without a Referral.

All copayments 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	ChoiceDocs = $10 Copay/visit; All other In-Network = $30 Copay/visit, Deductible does not apply	50% Coinsurance after Deductible	Copay does not apply to additional services.
	Specialist visit	ChoiceDocs = $30 Copay/visit; All other In-Network = $50 Copay/visit, Deductible does not apply	50% Coinsurance after Deductible	Copay does not apply to additional services.
	Preventive Care/Screening/immunization	No charge for listed preventive, Screening and immunization services. Deductible does not apply	No charge for listed immunizations, 50% Coinsurance after Deductible for preventive and Screening	You may have to pay for services that aren't preventive. Ask your Provider if the services needed are preventive. Then check what your Plan will pay for.
If you have a test	Diagnostic Test (x-ray, blood work)	20% Coinsurance after Deductible	50% Coinsurance after Deductible	---------- none ----------
	Imaging (CT/PET scans, MRIs)	$250 Copay/procedure, 20% Coinsurance after Deductible	$250 Copay/procedure, 50% Coinsurance after Deductible	Preauthorization required.

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 drugs to treat your illness or condition More information about prescription drug coverage is available at https://members.bcidaho.com/resources/pdfs/pharmacy/2020/Qualified-Health-Plan-Formulary.pdf	Generic drugs	Preferred=$10 Copay/prescription Non-preferred=$20 Copay/prescription (retail and mail order)	Preferred=$10 Copay/prescription Non-preferred=$20 Copay/prescription (retail and mail order)	Deductible does not apply. Covers up to a 90 day supply with multiple Copays. Additional Out-of-Network charges may apply.
	Preferred brand drugs	$35 Copay/prescription (retail and mail order)	$35 Copay/prescription (retail and mail order)	Deductible does not apply. Covers up to a 90 day supply with multiple Copays. Additional Out-of-Network charges may apply.
	Non-preferred brand drugs	$50 Copay/prescription (retail and mail order)	$50 Copay/prescription (retail and mail order)	Deductible does not apply. Covers up to a 90 day supply with multiple Copays. Additional Out-of-Network charges may apply.
	Specialty Drugs	Preferred=30% Coinsurance Non-preferred=50% Coinsurance (retail and mail order)	Preferred=30% Coinsurance Non-preferred=50% Coinsurance (retail and mail order)	Deductible does not apply. Coverage may include limitations and Preauthorization may be required. Additional Out-of-Network charges may apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance after Deductible	50% Coinsurance after Deductible	Preauthorization required.
	Physician/surgeon fees	10% Coinsurance after Deductible	50% Coinsurance after Deductible	Preauthorization required.
If you need immediate medical attention	Emergency Room Care	$350 facility Copay/visit after Deductible; other services 20% Coinsurance after Deductible	$350 facility Copay/visit after Deductible; other services 50% Coinsurance after Deductible	Out-of-Network services paid at In-Network if Emergency Medical Condition. Copay waived if admitted.
	Emergency Medical Transportation	20% Coinsurance after Deductible	50% Coinsurance after Deductible	---------- none ----------
	Urgent Care	$50 Copay/visit, Deductible does not apply	50% Coinsurance after Deductible	Copay does not apply to additional services.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance after Deductible	50% Coinsurance after Deductible	Preauthorization required.
	Physician/surgeon fee	20% Coinsurance after Deductible	50% Coinsurance after Deductible	Preauthorization required.

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 have mental health, behavioral health, or substance abuse services	Outpatient services	$30 Copay/visit, Deductible does not apply; 20% Coinsurance after Deductible for facility and other services	50% Coinsurance after Deductible	---------- none ----------
	Inpatient services	20% Coinsurance after Deductible	50% Coinsurance after Deductible	Preauthorization required.
If you are pregnant	Office Visits	20% Coinsurance after Deductible	50% Coinsurance after Deductible	For pregnancy services, Cost Sharing does not apply to certain Preventive Services. Depending on the type of services, a Copay, Coinsurance or Deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% Coinsurance after Deductible	50% Coinsurance after Deductible	---------- none ----------
	Childbirth/delivery facility services	20% Coinsurance after Deductible	50% Coinsurance after Deductible	---------- none ----------
If you need help recovering or have other special health needs	Home Health Care	20% Coinsurance after Deductible	50% Coinsurance after Deductible	Preauthorization required.
	ReHabilitation Services	20% Coinsurance after Deductible	50% Coinsurance after Deductible	Coverage is limited to 20 visit annual max.
	Habilitation Services	20% Coinsurance after Deductible	50% Coinsurance after Deductible	Coverage is limited to 20 visit annual max.
	Skilled Nursing Care	20% Coinsurance after Deductible	50% Coinsurance after Deductible	Coverage is limited to 30 day annual max.
	Durable Medical Equipment	20% Coinsurance after Deductible	50% Coinsurance after Deductible	Preauthorization required.
	Hospice Services	No charge. Deductible does not apply.	50% Coinsurance after Deductible	---------- none ----------

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 your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	50% Coinsurance, Deductible does not apply	Under the age of 19 only. VSP limits will apply.
	Children's glasses	No charge. Deductible does not apply.	50% Coinsurance, Deductible does not apply	Under the age of 19 only. VSP limits will apply.
	Children's dental check-up	Not covered	Not covered	---------- none ----------

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 other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up (Child)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Chiropractic care
- Eye exam (Child)
- Glasses (Child)
- Hearing aids (Child)
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

**** Group health coverage -**

There are agencies that can help if you want to continue coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-4444-EBSA(3272) or www.dol.gov/ebsa/healthreform; or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance through Your Health Idaho. For more information about Your Health Idaho, visit www.YourHealthIdaho.org or call 1-855-944-3246.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of 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 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:

For any initial questions concerning a claim, or to appeal a claim or benefit decision, please contact Customer Service at 1-208-286-3828 or 1-800-627-1188, www.bcidaho.com, or at P.O. Box 7408, Boise, ID 83707.

If your plan is subject to ERISA, you may contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA or www.dol.gov/ebsa/healthreform

If your plan is fully insured or self-funded and subject to the Idaho Insurance Code, you may also receive assistance from the Idaho Department of Insurance at 1-800-721-3272 or www.DOI.Idaho.gov

Does this plan provide Minimum Essential Coverage? **Yes.**

If you don't have Minimum Essential Coverage for a month, you will have to make payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for the month.

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.

----------*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)

The plan's overall deductible	$1,500
Specialist copay	$50
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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductible	$1,500
Copayments	$40
Coinsurance	$2,220
What isn't Covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,820**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist copay	$50
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
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductible	$130
Copayments	$1,640
Coinsurance	$0
What isn't Covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,825**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,500
Specialist 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	**$1,930**

In this example, Mia would pay:

Cost Sharing	
Deductible	$1,500
Copayments	$240
Coinsurance	$0
What isn't Covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,740**

Nondiscrimination Statement:
Discrimination is Against the Law

Blue Cross of Idaho complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Cross of Idaho does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Cross of Idaho:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Blue Cross of Idaho's Customer Service Department. Call 1-800-627-1188 (TTY: 1-800-377-1363), or call the customer service phone number on the back of your card.

If you believe that Blue Cross of Idaho has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with Blue Cross of Idaho's Grievances and Appeals Department at:

Manager, Grievances and Appeals
3000 East Pine Avenue, Meridian, Idaho 83642
Telephone: (800) 274-4018 ext.3838, Fax: (208) 331-7493
Email: grievances&appeals@bcidaho.com
TTY: 1-800-377-1363

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Grievances and Appeals team is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TTY).

Complaint forms are available at ***<http://www.hhs.gov/ocr/office/file/index.html>. Reference: <https://federalregister.gov/a/2016-11458>***

Language Assistance

ATTENTION: If you speak Arabic, Chinese, French, German, Korean, Japanese, Persian (Farsi), Romanian, Russian, Serbo-Croatian, Spanish, Sudanic Fulfulde, Tagalog, Ukrainian, or Vietnamese, language assistance services, free of charge, are available to you. Call 1-800-627-1188 (TTY: 1-800-377-1363).

Arabic

اهتف الصم ولابكم:1-800-377-1363). ملظوحة: إذ كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-627-1188 (رقم

Chinese 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-627-1188 (TTY： 1-800-377-1363)。

French ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-627-1188 (ATS : 1-800-377-1363).

German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-627-1188 (TTY: 1-800-377-1363).

Japanese 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-627-1188 (TTY: 1-800-377-1363) まで、お電話にてご連絡ください。

Korean 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-627-1188 (TTY: 1-800-377-1363)번으로 전화해 주십시오.

Persian-Farsi

فرا مهم می دشابر با (TTY: 1-800-377-1363) 1-800-627-1188 تماس بگیردیتوجه: گار به ابزن فارسی گفتگو می دینک تسهیلات یرنابز وصیرت لگیارن بریـا شما

Romanian ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-627-1188 (TTY: 1-800-377-1363).

Russian ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-627-1188 (телетайп: 1-800-377-1363).

Serbo-Croatian OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-627-1188 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-377-1363).

Spanish ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-627-1188 (TTY: 1-800-377-1363).

Sudanic Fulfulde MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-800-627-1188 (TTY: 1-800-377-1363).

Tagalog PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-627-1188 (TTY: 1-800-377-1363).

Ukrainian УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-627-1188 (телетайп: 1-800-377-1363).

Vietnamese CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-627-1188 (TTY: 1-800-377-1363).

Benefit Summary

GENERAL BENEFIT PLAN SUMMARY

Classic Foods, Inc
Group Number: 2309
Contract Effective Date: 03/01/2020

Benefit Overview	PPO	Premier	Non-Participating
Per Person Deductible Excluding Diagnostic and Preventive services per benefit year	$25	$50	$50
Family Deductible Excluding Diagnostic and Preventive services per benefit year	$75	$150	$150
Maximum Benefit Per eligible person per benefit year	$1,000	$750	$500
Services	**You pay the % below**		
Preventive & Diagnostic Services Examinations, X-rays, teeth cleaning	0%	0%	20%
Basic Services Fillings, root canals, extractions, oral surgery	20%	40%	60%
Major Services Crowns, onlays, bridges, dentures Late enrollee waiting period is 12 months	50%	100%	100%

PARTICIPATING AND NON-PARTICIPATING DENTISTS

If the dentist is a PPO or Premier participating dentist, Delta Dental will base payment on the lesser of the Submitted Amount or the Contract Fee. Delta Dental will send payment to the participating dentist and the subscriber will be responsible for any co-payment and/or any non-covered services.

If the dentist is a non-participating dentist, Delta Dental will base payment on the lesser of the Submitted Amount or Delta Dental's non-participating dentist Fee. It is the subscriber's responsibility to make full payment to the non-participating Dentist. For dental services rendered by an out-of-state dentist, Delta Dental will base payment on the lesser of the Submitted Amount or the Contract Fee in that area, if the out-of-state dentist is a participating dentist with a Delta Dental plan in the state in which the service is rendered.

Benefits and Limitations

Class I Preventive and Diagnostic Services
Examinations once every 6 months.
Cleanings once every 6 months (restricts against periodontal maintenance within the same time period).
Fluoride two times in any 12 consecutive month period for dependent children under age 19.
Full mouth series or panoramic X-rays once every 5 years.
Bitewing X-rays once every 12 months.
Class II Basic Services
Periodontal maintenance is allowed 4 times in 12 months if patient has had previously treated periodontal disease.
Scaling and root planing covered once per quadrant every 24 months. Periodontal surgery is payable once per quadrant in any 3 year period.
Fillings restricted to same tooth/surface once every 24 months.
Class III Major Restorative Services
Crowns, build-ups, stainless steel crowns, onlays, or bridges on same tooth once every 7 years.
Porcelain, porcelain substrate, and cast restorations are not payable for children less than 12 years.
Partials, or dentures 1 time per arch every 7 years, eligible for partials at age 16.
Implants
Implants are a covered benefit per tooth with a maximum lifetime benefit of $1,200 or the plan's annual maximum, whichever is less (Ages 19 and over).
Dependents
Eligible children must be under age 26.

GENERAL PLAN INFORMATION

1. Optional treatment: If the subscriber or eligible dependent selects a more expensive service than is customarily provided. For example, if teeth can be restored satisfactorily with amalgam or composite material, the cost of inlays, onlays and crowns are not covered and the cost difference between the covered and the non-covered procedure is to be borne by the patient.
2. Payment provisions: The following guidelines will be used to determine the date on which a service shall be paid:
   a. Full dentures or partial dentures: On the date the final impression is taken.
   b. Fixed bridges, crowns, and onlays: On the date the tooth or teeth are prepared.
   c. Root canal therapy: On the date the root canal is initiated.

3. Processing Policies may limit benefits. Processing Policies applied to a claim are noted on the Explanation of Benefits (EOB).
4. Predeterminations: If your dental treatment involves services of $300 or greater, it is advisable to ask your dentist to submit a predetermination of benefits. A statement will be sent to you and your dentist estimating the amount of Delta Dental payment obligation and the amount that you will owe. These estimates will be subject to your continuing eligibility in the plan and the group contract remaining in effect. If claims for other completed dental services are received and processed prior to the completion date of the proposed treatment, this may reduce Delta Dental's estimated payment for the proposed treatment and increase your obligation to the dentist. Predeterminations are valid for ninety (90) days from the date issued by Delta Dental.

WHAT SERVICES ARE NOT COVERED?

No payment will be made by Delta Dental and all charges for the following services will be the responsibility of the subscriber:

1. Services for injuries or conditions payable under Workers' Compensation or Employer's Liability laws. Benefits or services that are available from any government agency, political subdivision, community agency, foundation, or similar entity. This provision does not apply to any programs provided under Title XIX Social Security Act, i.e., Medicaid.
2. Services for cosmetic surgery, or dentistry for aesthetic reasons.
3. Services or appliances started before an individual became eligible under the contract.
4. Prescription drugs, pre-medications and/or relative analgesia. General anesthesia and/or intravenous sedation other than for covered oral surgery. Charges for hospitalization, laboratory tests, and examinations and any additional fees charged by the dentist for hospital treatment.
5. Preventive control programs, including home care items.
6. Charges for failure to keep a scheduled visit with the dentist.
7. Repair, relines, or adjustments of occlusal guards.
8. Charges for completion of forms. A participating dentist may not make these charges to a subscriber or eligible dependent.
9. Prosthodontic services (Class III benefits), unless specified as a covered service in the Benefit Summary.
10. Orthodontic services (Class IV benefits), unless specified as a covered service in the Benefit Summary.
11. Lost, missing, or stolen appliances of any type and replacement or repair of orthodontic appliances.
12. Services for which no valid dental need can be demonstrated, that are specialized techniques, or that are experimental in nature as determined by the standards of generally accepted dental practice.
13. Appliances, surgical procedures, and restorations for increasing vertical dimension; for restoring occlusion; for replacing tooth structure loss resulting from attrition, abrasion, or erosion. If orthodontic benefits have been selected under this contract, this exclusion will not apply to the orthodontic services.
14. Treatment by other than a dentist, except for services performed by a licensed dental hygienist or denturist within the scope of his or her license.
15. Processing Policies may limit benefits. Processing Policies applied to a claim are noted on the Explanation of Benefits (EOB).
16. Services or supplies for which no charge is made, or for which the patient is not legally obligated to pay. This includes services or supplies furnished by a dentist who is related to the patient by blood or who is related to the patient by blood or marriage and who ordinarily dwells in the patient's household, the dentist providing service to him/her self, or services which would not have a charge in the absence of Delta Dental coverage.
17. Services or supplies received as a result of defect, or injury due to an act of war, declared or undeclared.
18. Services that are covered under a hospital, surgical/medical, or prescription drug program.
19. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).
20. Myofunctional therapy.
21. Delta Dental is not obligated to pay claims received more than 12 months after the date of service.

22. Nutritional counseling, tobacco counseling and oral hygiene instruction are not covered benefits except for participants in Delta Dental's Health through Oral Wellness® (HOW®) program.

This is only a general summary of benefits. It provides a brief description about the important features of this policy and does not constitute a contract or guarantee of payment. Full terms and conditions are set forth in the policy provisions. If you have any questions about your plan's benefits or would like to submit a predetermination before services are performed, please call Delta Dental of Idaho customer service advisors at (208) 489-3580 or toll-free at (800) 356-7586. You may also log onto our website, www.deltadentalid.com, for benefit and eligibility information or up-to-date claim status.

Delta Dental of Idaho
555 E Parkcenter Blvd
Boise, ID 83706-6503

Customer Service
(208) 489-3580
(800) 356-7586

Get access to the best in eye care and eyewear with UNITED HERITAGE LIFE INSURANCE COMPANY and VSP® Vision Care.

As a VSP member, you have access to care from great eye doctors, quality eyewear, and the affordability you deserve, all at the lowest out-of-pocket costs.

You'll like what you see with VSP.

- **Value and Savings.** You'll enjoy more value and the lowest out-of-pocket costs.
- **High Quality Vision Care.** You'll get the best care from a VSP network doctor, including a WellVision Exam®—the most comprehensive exam designed to detect eye and health conditions.
- **Choice of Providers.** The decision is yours to make—choose a VSP network doctor, a participating retail chain, or any out-of-network provider.
- **Great Eyewear.** It's easy to find the perfect frame at a price that fits your budget.

Using your VSP benefit is easy.

- **Create an account at vsp.com**. Once your plan is effective, review your benefit information.
- **Find an eye doctor who's right for you.** Visit **vsp.com** or call **800.877.7195**.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com**.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like bebe®, CALVIN KLEIN, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more.[1] Visit **vsp.com** to find a Premier Program location that carries these brands. Plus, save up to 40% on popular lens enhancements.[2] Prefer to shop online? Check out all of the brands at **eyeconic.com®**, VSP's preferred online eyewear store.

VSP® Vision care for life | UNITED HERITAGE Insurance

See why we're consumers' #1 choice in vision care[3].

Contact us. **800.877.7195**
vsp.com

Your VSP Vision Benefits Summary

United Heritage Life Insurance Company and VSP provide you with an affordable eye care plan.

VSP Provider Network: VSP Choice

Benefit	Description	Copay	Frequency
Your Coverage with a VSP Provider			
WellVision Exam	• Focuses on your eyes and overall wellness	$10	Every 12 months
Prescription Glasses		$25	See frame and lenses
Frame	• $130 allowance for a wide selection of frames • $150 allowance for featured frame brands • 20% savings on the amount over your allowance • $70 Costco® frame allowance	Included in Prescription Glasses	Every 12 months
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every 12 months
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements	$55 $95 - $105 $150 - $175	Every 12 months
Contacts (instead of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation), billed amount not to exceed $60		Every 12 months
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		
	Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

Your Coverage with Out-of-Network Providers

Get the most out of your benefits and greater savings with a VSP network doctor. Your coverage with out-of-network providers will be less or you'll receive a lower level of benefits. Visit **vsp.com** for plan details.

Exam ..... up to $45	Lined Bifocal Lenses ..... up to $50	Progressive Lenses ..... up to $50
Frame ..... up to $70	Lined Trifocal Lenses ..... up to $65	Contacts ..... up to $105
Single Vision Lenses ..... up to $30		

Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

This Benefit Summary is not part of your group's Policy or the Certificate of Coverage. The policy and certificate may contain certain Limitations and Exclusions not stated in this Benefit Summary. Please see the issued Policy and Certificate of Coverage for specific plan information.

Contact us. **800.877.7195** | **vsp.com**

1. Brands/Promotion subject to change.
2. Savings based on network doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Available only through VSP network doctors to VSP members with applicable plan benefits. Ask your VSP network doctor for details.

3. 2017 National Vision Plan Member Research.

BENEFITS AT A GLANCE

LIFE INSURANCE PLAN

This life insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death. The amount your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death according to the terms and provisions of the plan. You also have the opportunity to have coverage for your dependents.

EMPLOYER'S ORIGINAL PLAN EFFECTIVE DATE: May 1, 2013

IDENTIFICATION NUMBER: 608164 001

ELIGIBLE GROUP(S):

Salaried Management in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Employees must be working at least 30 hours per week.

WAITING PERIOD:

For employees in an eligible group on or before May 1, 2013: First of the month coincident with or next following 3 months of continuous active employment

For employees entering an eligible group after May 1, 2013: First of the month coincident with or next following 3 months of continuous active employment

REHIRE:

If your employment ends and you are rehired within 1 year, your previous work while in an eligible group will apply toward the waiting period. All other Summary of Benefits' provisions apply.

CREDIT PRIOR SERVICE:

Unum will apply any prior period of work with your Employer toward the waiting period to determine your eligibility date.

WHO PAYS FOR THE COVERAGE:

For You:

Owners
You pay the cost of your coverage.

All Full-Time Salaried Management Excluding Owners
Your Employer pays the cost of your coverage.

For Your Dependents:

Your Employer pays the cost of your dependent coverage.

ELIMINATION PERIOD:

Premium Waiver: 9 months

Disability-based benefits begin the day after Unum approves your claim and the elimination period is completed.

LIFE INSURANCE BENEFIT:

AMOUNT OF LIFE INSURANCE FOR YOU

$30,000

AMOUNT OF LIFE INSURANCE AVAILABLE IF YOU BECOME INSURED AT CERTAIN AGES OR HAVE REACHED CERTAIN AGES WHILE INSURED

If you have reached age 70, but not age 75, your amount of life insurance will be:
- 65% of the amount of life insurance you had prior to age 70; or
- 65% of the amount of life insurance shown above if you become insured on or after age 70 but before age 75.

There will be no further increases in your amount of life insurance.

If you have reached age 75 or more, your amount of life insurance will be:
- 50% of the amount of life insurance you had prior to your first reduction; or
- 50% of the amount of life insurance shown above if you become insured on or after age 75.

There will be no further increases in your amount of life insurance.

AMOUNT OF LIFE INSURANCE FOR YOUR DEPENDENTS

Spouse:

$2,000

Children:

Live birth to 14 days:	$1,000
14 days to 6 months:	$1,000
6 months to age 19 or to 26 if a full-time student:	$2,000

THE AMOUNT OF LIFE INSURANCE FOR A DEPENDENT WILL NOT BE MORE THAN 100% OF YOUR AMOUNT OF LIFE INSURANCE.

SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.

OTHER FEATURES:

Accelerated Benefit

Conversion

Portability

NOTE: Portability under this plan is available to an insured spouse in the event of divorce from an insured employee, subject to all terms and conditions otherwise applicable to ported spouse coverage.

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section.

Accident Insurance

Colonial Life®
Making benefits count.

Accidents happen in places where you and your family spend the most time – at work, in the home and on the playground – and they're unexpected. How you care for them shouldn't be.

In your lifetime, which of these accidental injuries have happened to you or someone you know?

- Sports-related accidental injury
- Broken bone
- Burn
- Concussion
- Laceration
- Back or knee injuries
- Car accidents
- Falls & spills
- Dislocation
- Accidental injuries that send you to the Emergency Room, Urgent Care or doctor's office

Colonial Life's Accident Insurance is designed to help you fill some of the gaps caused by increasing deductibles, co-payments and out-of-pocket costs related to an accidental injury. The benefit to you is that you may not need to use your savings or secure a loan to pay expenses. Plus you'll feel better knowing you can have greater financial security.

What additional features are included?

- Worldwide coverage
- Portable
- Compliant with Healthcare Spending Account (HSA) guidelines

Will my accident claim payment be reduced if I have other insurance?

You're paid regardless of any other insurance you may have with other insurance companies, and the benefits are paid directly to you (unless you specify otherwise).

What if I change employers?

If you change jobs or leave your employer, you can take your coverage with you at no additional cost. Your coverage is guaranteed renewable as long as you pay your premiums when they are due or within the grace period.

Can my premium change?

Colonial Life can change your premium only if we change it on all policies of this kind in the state where your policy was issued.

How do I file a claim?

Visit coloniallife.com or call our Customer Service Department at 1.800.325.4368 for additional information.

Benefits listed are for each covered person per covered accident unless otherwise specified.

Initial Care

- Accident Emergency Treatment.....$125
- X-ray Benefit.....$40
- Ambulance.....$200
- Air Ambulance.....$2,000

Common Accidental Injuries

Dislocations (Separated Joint)	Non-Surgical	Surgical
Hip	$2,200	$4,400
Knee (except patella)	$1,100	$2,200
Ankle – Bone or Bones of the Foot (other than Toes)	$880	$1,760
Collarbone (Sternoclavicular)	$550	$1,100
Lower Jaw, Shoulder, Elbow, Wrist	$330	$660
Bone or Bones of the Hand	$330	$660
Collarbone (Acromioclavicular and Separation)	$110	$220
One Toe or Finger	$110	$220

Fractures	Non-Surgical	Surgical
Depressed Skull	$2,750	$5,500
Non-Depressed Skull	$1,100	$2,200
Hip, Thigh	$1,650	$3,300
Body of Vertebrae, Pelvis, Leg	$825	$1,650
Bones of Face or Nose (except mandible or maxilla)	$385	$770
Upper Jaw, Maxilla	$385	$770
Upper Arm between Elbow and Shoulder	$385	$770
Lower Jaw, Mandible, Kneecap, Ankle, Foot	$330	$660
Shoulder Blade, Collarbone, Vertebral Process	$330	$660
Forearm, Wrist, Hand	$330	$660
Rib	$275	$550
Coccyx	$220	$440
Finger, Toe	$110	$220

Your Colonial Life policy also provides benefits for the following injuries received as a result of a covered accident.

- Burn (based on size and degree).....$1,000 to $12,000
- Coma.....$12,500
- Concussion.....$60
- Emergency Dental Work.....$100 Extraction, $400 Crown, Implant, or Denture
- Lacerations (based on size).....$30 to $500

Requires Surgery

- Eye Injury.....$300
- Tendon/Ligament/Rotator Cuff.....$750 - one, $1,500 - two or more
- Ruptured Disc.....$750
- Torn Knee Cartilage.....$750

Surgical Care

- Surgery (cranial, open abdominal or thoracic).....$1,500
- Surgery (hernia).....$150
- Surgery (arthroscopic or exploratory).....$200
- Blood/Plasma/Platelets.....$300

Transportation/Lodging Assistance

If injured, covered person must travel more than 50 miles from residence to receive special treatment and confinement in a hospital.

- Transportation ..... $600 per round trip up to 3 round trips
- Lodging (family member or companion) ..... $150 per night up to 30 days for a hotel/motel lodging costs

Accident Hospital Care

- Hospital Admission* ..... $1,000 per accident
- Hospital ICU Admission* ..... $2,000 per accident

** We will pay either the Hospital Admission or Hospital Intensive Care Unit (ICU) Admission, but not both.*

- Hospital Confinement ..... $225 per day up to 365 days per accident
- Hospital ICU Confinement ..... $450 per day up to 15 days per accident

Accident Follow-Up Care

- Accident Follow-Up Doctor Visit ..... $50 (up to 4 visits per accident)
- Medical Imaging Study ..... $200 per accident (limit 1 per covered accident and 1 per calendar year)
- Occupational or Physical Therapy ..... $35 per treatment up to 10 days
- Appliances ..... $100 (such as wheelchair, crutches)
- Prosthetic Devices/Artificial Limb ..... $750 - one, $1,500 - more than 1
- Rehabilitation Unit ..... $150 per day up to 15 days per covered accident, and 30 days per calendar year. Maximum of 30 days per calendar year

Accidental Dismemberment

- Loss of Finger/Toe ..... $1,250 – one, $2,400 – two or more
- Loss or Loss of Use of Hand/Foot/Sight of Eye ..... $12,000 – one, $24,000 – two or more

Catastrophic Accident

For severe injuries that result in the total and irrecoverable:

- Loss of one hand and one foot
- Loss of both hands or both feet
- Loss or loss of use of one arm and one leg or
- Loss or loss of use of both arms or both legs
- Loss of the sight of both eyes
- Loss of the hearing of both ears
- Loss of the ability to speak

Named Insured ..... $25,000 Spouse ..... $25,000 Child(ren) $12,500

365-day elimination period. Amounts reduced for covered persons age 65 and over. Payable once per lifetime for each covered person.

Accidental Death

	Accidental Death	Common Carrier
• Named Insured	$50,000	$200,000
• Spouse	$50,000	$200,000
• Child(ren)	$10,000	$40,000

My Coverage Worksheet (For use with your Colonial Life benefits counselor)

Who will be covered? (check one)

○ Employee Only ○ Spouse Only ○ One Child Only ○ Employee & Spouse

○ One-Parent Family, with Employee ○ One-Parent Family, with Spouse ○ Two-Parent Family

When are covered accident benefits available? (check one)

○ On and Off -Job Benefits ○ Off -Job Only Benefits

We will not pay benefits for losses that are caused by or are the result of: elective abortion; felonies or illegal occupations; professional sports; sickness; suicide or self-inflicted injuries; war or armed conflict; in addition to the exclusions listed above, we also will not pay the Catastrophic Accident benefit for injuries that are caused by or are the result of: birth; intoxication.

For cost and complete details, see your Colonial Life benefits counselor. Applicable to policy form Accident 1.0-NS-ID. This is not an insurance contract and only the actual policy provisions will control.

Accident 1.0-Premier-ID

Colonial Life
1200 Colonial Life Boulevard
Columbia, South Carolina 29210
coloniallife.com

10/11

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A Leavitt Group Company

2019 Wendy's of Idaho Contact Sheet

Medical, Group ID#10037023:		
Blue Cross of Idaho	www.bcidaho.com	1-800-627-1188
Dental, Group ID# 2309:		
Delta Dental of Idaho	www.deltadentalid.com	1-208-489-3582
Vision, Group ID# 03761		
United Heritage / VSP	www.vsp.com	1-208-493-6100
Colonial, Group ID#C6081145		
Colonial	www.coloniallife.com	1-800-325-4368
UNUM, Group ID#608164		
UNUM	www.unum.com	1-800-ASK-UNUM

Your American Insurance / GBS of Idaho team is available to answer any questions:

Travis Argyle	travis.argyle@gbsbenefits.com	208-529-3541
AJ Argyle	aj.argyle@gbsbenefits.com	208-529-3541
Tina Prestwich	tina.prestwich@gbsbenefits.com	208-529-3541
Angel Runnels	angel.runnels@gbsbenefits.com	208-529-3541