US Foods: BCBSIL – Blue Value Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2017 – 12/31/2017

Coverage for: All Tiers | Plan Type: PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.usfbenefitscenter.com or by calling 1-888-316-7700.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**In-Network:** **$1,000** individual/**$2000** 2 person/**$2,000** family **Out-of-Network*:** **$3,000** individual/**$6,000** 2 person/**$6,000** family *Doesn't apply to preventive care	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	There are no other specific **deductibles**.	
Is there an out–of–pocket limit on my expenses?	**In-Network:** **$5,000** individual/**$10,000** 2 person/**$10,000** family **Out-of-Network:** **$10,000** individual/**$20,000** 2 person/**$20,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. Your deductible, copays and coinsurance for both medical and prescriptions all count towards your annual out-of-pocket limit.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care that this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

Questions: Call the US Foods Benefits Center toll free at **1-888-316-7700** or visit us at **www.usfbenefitscenter.com**. Ifyou aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call **1-888-316-7700** to request a copy.

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Does this plan use a network of providers?	Yes. See www.bcbsil.com **or call 1-888-316-7700** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services.**

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay	50% after deductible	none
	Specialist visit	20% after deductible	50% after deductible	none
	Other practitioner office visit	20% after deductible	50% after deductible	none
	Preventive care/screening/immunization	No charge	50% after deductible	none
If you call MDLive	Telemedicine	20% after deductible	Not applicable	none
If you have a test	Diagnostic test (x-ray, blood work)	20% after deductible	50% after deductible	none
	Imaging (CT/PET scans, MRIs)	20% after deductible	50% after deductible	Pre-Authorization for all elective MRIs and CT scans. Call 1-888-316-7700

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www. caremark.com**	**CVS Caremark Rx Plan**	**Retail**		For a list of preventive medications call **1-888-316-7700** or log on to **www.caremark.com** Retail Rx up to 30-day supply Mail Order Rx up to 90-day supply After two 30-day refills of maintenance meds must go to mandatory mail. Employee pays 100% of Rx drug cost until they reach their deductible then employee pays copay or coinsurance noted (subject to applicable minimums or maximums)
	Preventive Generic and/or Brand (w/o generic equal) Medications	No cost	Check with plan	
	Generic drugs	$10 copay after deductible	Check with plan	
	Preferred brand drugs	30% coinsurance $25 minimum $75 maximum	Check with plan	
	Non-Preferred brand drugs	50% coinsurance $75 minimum $150 maximum	Check with plan	
	CVS Caremark Rx Plan	**Mail Order**		
	Preventive Generic and/or Brand (w/o generic equal) Medications	No cost	Check with plan	
	Generic drugs	$20 copay after deductible	Check with plan	
	Preferred brand drugs	30% coinsurance $50 minimum $150 maximum	Check with plan	
	Non-Preferred brand drugs	50% coinsurance $150 minimum $300 maximum	Check with plan	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	50% coinsurance after deductible	none
	Physician/surgeon fees	20% coinsurance after deductible	50% coinsurance after deductible	none
If you need immediate medical attention	Emergency room services	20% coinsurance after deductible	50% coinsurance after deductible	If the visit to the ER is determined to be a non-emergency, you pay 50% after deductible

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
	Emergency medical transportation	20% coinsurance after deductible	50% coinsurance after deductible	none
	Urgent care	20% coinsurance after deductible	50% coinsurance after deductible	none
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	50% coinsurance after deductible	Pre-authorization required for all hospital stays
	Physician/surgeon fee	20% coinsurance after deductible	50% coinsurance after deductible	none
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance after deductible	50% coinsurance after deductible	none
	Mental/Behavioral health inpatient services	20% coinsurance after deductible	50% coinsurance after deductible	Pre-authorization required for all hospital stays
	Substance use disorder outpatient services	20% coinsurance after deductible	50% coinsurance after deductible	none
	Substance use disorder inpatient services	20% coinsurance after deductible	50% coinsurance after deductible	Pre-authorization required for all hospital stays
If you are pregnant	Prenatal and postnatal care	20% coinsurance after deductible	50% coinsurance after deductible	none
	Delivery and all inpatient services	20% coinsurance after deductible	50% coinsurance after deductible	Pre-authorization required for all hospital stays $250 penalty towards inpatient delivery claims if not enrolled in Special Beginnings program in the 1st trimester.

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	50% coinsurance after deductible	Maximum 120 days per year; separate from private duty nursing maximum
	Rehabilitation services	20% coinsurance after deductible	50% coinsurance after deductible	Combined maximum of 8 initial visits, then up to 52 visits per year for each qualifying condition with pre-authorization; includes physical, speech and occupational therapy
	Habilitation services	20% coinsurance after deductible	50% coinsurance after deductible	Combined maximum of 8 initial visits, then up to 52 visits per year for each qualifying condition with pre-authorization; includes physical, speech and occupational therapy
	Skilled nursing care	20% coinsurance after deductible	50% coinsurance after deductible	Maximum 100 days per year; no prior hospitalization required; prior authorization required
	Durable medical equipment	20% coinsurance after deductible	50% coinsurance after deductible	none
	Hospice service	20% coinsurance after deductible	50% coinsurance after deductible	none
If your child needs dental or eye care	Eye exam (preventive screening only for children)	Not Covered	Not Covered	Not Covered
	Glasses	Not Covered	Not Covered	Not Covered
	Dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Experimental or investigational procedures and treatments not approved by the American Medical Association
- Hearing Aids
- Infertility Treatment (covered only for diagnostic services)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Organ transplants that are considered experimental or not medically appropriate
- Over-the-counter disposable or consumable supplies including orthotics and other devices
- Routine eye care (Adult)
- Routine foot care
- Services not medically necessary
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric surgery (Please contact BCBSIL for details. Must be performed at Blue Distinction Center of Bariatric Surgery)
- Chiropractic care
- For coverage provided outside the United States. See **www.bcbsil.com**
- Private-duty nursing
- Telemedicine

Group Health Coverage

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-316-7700. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Blue Cross & Blue Shield of Illinois at **1-888-316-7700** for further assistance. You may also contact the department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-888-316-7700**
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-888-316-7700**
Chinese (41i (): 如果需要 41i (的帮助, **请拨打这个号码 1-888-316-7700**
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-888-316-7700**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7540**
- **Plan pays $5260**
- **Patient pays $2280**

Sample care costs:

Hospital charges (mother, 3 days)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby, 3 days)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions (generic)	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1000
Copays	$10
Coinsurance	$1270
Limits or exclusions	$0
Total	**$2280**

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact 1-888-316-7700.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5400**
- **Plan pays $4005**
- **Patient pays $1395**

Sample care costs:

Prescriptions (Preferred)	$2,900
Medical Equipment and Supplies	$1,300
Office Visits & Procedures (4 visits)	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1000
Copays	$195
Coinsurance	$200
Limits or exclusions	$0
Total	**$1395**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The expectant mother was enrolled in the Special Beginnings program by their first trimester.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

X **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

X **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

☐ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

☐ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.