Perdue Farms, Inc BluePreferred Essential 20 Plan

Coverage Period: 01/01/2018 – 12/31/2018

Coverage for: Employee Only, Employee + Spouse, Employee + Children, Family| **Plan Type:** PPO

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 general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can see the Glossary at www.carefirst.com/sbcg or call 1-855-258-6518 to request a copy. For more information about your coverage, or to get a copy of the complete terms of coverage, please visit www.carefirst.com.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $1,200 individual/ $2,400 family Out-of-Network: $2,400 individual/ $4,800 family	Generally, you must pay all 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, all In-Network preventive care Services and prescription drugs.	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?	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: $6,000 individual/$12,000 family Out-of-Network: $12,000 individual/$24,000 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 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, health care this plan doesn't cover, most out-of-network coinsurance you pay, and penalties for failure to obtain pre-authorization for services.	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.carefirst.com or call 1-844-405-2160 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 you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Specialist visit	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Retail health clinic	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Preventive care/screening/ immunization	No Charge	Deductible, then 30% of Allowed Benefit	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. Some services may have limitations or exclusions. Please see your contract.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Imaging (CT/PET scans, MRIs)	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.expressscripts.com	Generic non-specialty drugs	Retail: 20%, subject to $8 minimum and $16 maximum Mail Order: 20%, subject to $16 minimum, $32 maximum	Not covered	Drugs not listed on the formulary are not covered. ◆ Retail non-specialty drugs are limited to a 30-day supply. Mail Order non-specialty drugs are limited to a 90-day supply. All specialty drugs are limited to a 30-day supply and most must be obtained (after the first fill) through Express Scripts' home delivery service, Accredo. ◆ If a brand drug is requested when a generic drug is available, you pay the generic copay plus the difference in cost between the brand drug and the generic drug. ◆ Over-the-counter and erectile dysfunction drugs are not covered. ◆ Lifetime maximum of $10,000 for fertility drugs. ◆ Prior authorization and step therapy are required for certain drug categories. Without prior authorization and step therapy, the drugs are not covered.
	Preferred brand non-specialty drugs	Retail: 20%, subject to $30 minimum and $60 Mail Order: 30%, subject to $50 minimum, $100 maximum	Not covered	
	Generic specialty drugs	Retail and Mail Order: 20%, subject to $16 minimum, $32 maximum	Not covered	
	Preferred brand Specialty drugs	Retail and Mail Order: 30%, subject to $50 minimum, $100 maximum	Not covered	
	Insulin, syringes, and diabetic supplies	Retail copay applies to both Retail and Mail Order prescriptions and supplies	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	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)	
	Physician/surgeon fees	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
If you need immediate medical attention	Emergency room care	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Limited to Emergency Services or unexpected, urgently required services. For other services, you pay: deductible, then $100 copay, then 50% of Allowed Benefit (copay waived if admitted).
	Emergency medical transportation	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	None
	Urgent care	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Out-of-Network: Without prior authorization, the Allowed Benefit is reduced by 50%.
	Physician/surgeon fees	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Out-of-Network: Without prior authorization, the Allowed Benefit is reduced by 50%.
If you are pregnant	Office visits	No Charge	Deductible, then 30% of Allowed Benefit	"No Charge" applies to routine pre/postnatal visits only.
	Childbirth/delivery professional services	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Childbirth/delivery facility services	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	None
If you need help recovering or have other special health needs	Home health care	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Treatment plan must be approved before benefits will be paid. Benefits are limited to 20 visits per benefit period.
	Rehabilitation services	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Benefits are limited to 25 visits per benefit period for each type of therapy (Occupational, Speech, and Physical).
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Out-of-Network Skilled Nursing Facility: Without prior authorization, the Allowed Benefit is reduced by 50%. Benefits are limited to 60

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)	
				days per benefit period. Admission must be within 14 days of a hospital confinement of at least 3 days. Outpatient Private Duty Nursing: Prior authorization is required. Without prior authorization, benefits will not be paid. Benefits are limited to 20 days per benefit period.
	Durable medical equipment	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Hospice services	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Benefits are limited to 240 days per benefit period.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	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 any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Habilitation Services
- Hearing aids
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs
- Non-surgical care for temporomandibular joint disorder (TMJ) (plan pays up to a lifetime max of $600)

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

- Chiropractic care (limited to 25 visits per benefit period)
- Coverage provided outside the US. See www.carefirst.com
- Non-emergency care when travelling outside the US
- Private-duty nursing (limited to 20 days per benefit period)

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 Employee Benefits Security Administration, http://www.dol.gov/ebsa/healthreform, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, http://www.cciio.cms.gov, or call 1-877-267-2323 x61565. 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 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: Department of Labor Employee Benefits Security Administration, http://www.dol.gov/ebsa/healthreform, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, http://www.cciio.cms.gov, or call 1-877-267-2323 x61565.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that 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.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al 1-855-258-6518.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-6518.]
[Chinese (中文): 如果需要中文的帮助，□□打□个号□ 1-855-258-6518.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-258-6518.]

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.

■ The plan's overall deductible	$1,200
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,200
Copayments	$0
Coinsurance	$1,822
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,032**

■ The plan's overall deductible	$1,200
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,200
Copayments	$0
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,400**

■ The plan's overall deductible	$1,200
■ Specialist coinsurance	20%
■ 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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,200
Copayments	$0
Coinsurance	$140
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,340**

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