Perdue Farms, Inc-Natural Food Holdings BluePreferred Basic 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: $600 individual/ $1,200 family Out-of-Network: $1,200 individual/ $2,400 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 Medical: $1,800 individual/$3,600 family Out-of-Network Medical: $3,600 individual/$7,200 family Prescription Drug Program: $4,800 individual/$9,600 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, 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	Provider: $30 copay per visit Hospital Facility: Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
	Specialist visit	Provider: $30 copay per visit Hospital Facility: Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
	Retail health clinic	$30 copay per visit	Deductible, then 40% of Allowed Benefit	None
	Preventive care/screening/ immunization	No Charge	Deductible, then 40% 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)	No Charge	Deductible, then 40% of Allowed Benefit	None
	Imaging (CT/PET scans, MRIs)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% 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)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.expressscripts.com	Generic drugs	Non-specialty: Retail: $10 copay Mail Order: $20 copay Specialty: Retail: $10 copay Mail Order: $10 copay	Same copays as in-network, plus amounts over the in-network rate (balance billed.)	◆ Retail non-specialty limited to a 31-day supply. ◆ Mail Order non-specialty limited to a 93-day supply. All specialty drugs limited to a 30-day supply. ◆ Over-the-counter and erectile dysfunction drugs are not covered. ◆ Prior authorization and step therapy are required for certain drug categories. Without prior authorization and step therapy, the drugs are not covered.
	Preferred brand drugs	Non-specialty: Retail: $30 copay Mail Order: $60 copay Specialty: Retail: $30 copay Mail Order: $30 copay	Same copays as in-network, plus amounts over the in-network rate (balance billed).	
	Non-preferred brand drugs (non-specialty & specialty)	Non-specialty: Retail: $60 copay Mail Order: $120 copay Specialty: Retail: $60 copay Mail Order: $60 copay	Same copays as in-network, plus amounts over the in-network rate (balance billed.)	
	Insulin, syringes, and diabetic supplies.	Retail: $10 copay Mail Order: $10 copay	Same copays as in-network, plus amounts over the in-network rate (balance billed).	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
	Physician/surgeon fees	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
If you need immediate medical attention	Emergency room care	Deductible, then 20% of Allowed Benefit	In-Network Deductible, then 20% of Allowed Benefit	None
	Emergency medical transportation	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	None
	Urgent care	$30 copay per visit	Deductible, then 40% of Allowed Benefit	None
If you have a	Facility fee (e.g., hospital room)	Deductible, then 20% of	Deductible, then 40% of	Out-of-Network: Without prior authorization, the

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)	
hospital stay		Allowed Benefit	Allowed Benefit	Allowed Benefit is reduced by 50% (reduction not to exceed $1000).
	Physician/surgeon fees	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visits: No Charge Hospital Facility: Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
	Inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Out-of-Network: Without prior authorization, the Allowed Benefit is reduced by 50% (reduction not to exceed $1000).
If you are pregnant	Office visits	No Charge	Deductible, then 40% of Allowed Benefit	"No Charge" applies to routine pre/postnatal visits only.
	Childbirth/delivery professional services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
	Childbirth/delivery facility services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% 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 40% of Allowed Benefit	Out-of-Network: Without prior authorization, the Allowed Benefit is reduced by 50% (reduction not to exceed $1000). Benefits are limited to 100 visits per benefit period.
	Rehabilitation services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Benefits are limited to 30 visits per benefit period for Speech Therapy, 60 combined visits per benefit period for Physical and Occupational Therapies, and 90 visits per benefit period for Cardiac Rehab.
	Habilitation services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Benefits are limited to 30 visits per benefit period for Speech Therapy, 60 combined visits per benefit period for Physical and Occupational Therapies, and 90 visits per benefit period for Cardiac Rehab.
	Skilled nursing care	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Out-of-Network Skilled Nursing Facility: Without prior authorization, the Allowed Benefit is reduced by 50% (reduction not to exceed $1000). Benefits are limited to 100 days per benefit period.

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)	
				Outpatient Private Duty Nursing: Prior authorization is required. Without prior authorization, benefits will not be paid. Benefits are limited to 30 days per benefit period.
	Durable medical equipment	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
	Hospice services	Inpatient & Outpatient Care: Deductible, then 20% of Allowed Benefit	Inpatient & Outpatient Care: Deductible, then 40% of Allowed Benefit	Without prior authorization, the Allowed Benefit is reduced by 50% (reduction not to exceed $1000). Limited to 185 days per lifetime for hospice care, 15 days per lifetime for inpatient hospice respite care, 15 days per lifetime for outpatient hospice respite care. Respite care must be used in increments of no more than 5 days at a time.
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) • Long-term care • Hearing aids • Infertility treatment	• 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 (limited to 12 visits per coverage period)	• Coverage provided outside the US. See www.carefirst.com	• Private-duty nursing (limited to 30 days per coverage period) • Non-emergency care when travelling outside the US

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	$600
■ Specialist copayment	$30
■ Hospital (facility) coinsurance	20%
■ Other copayment	$0

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	$600
Copayments	$0
Coinsurance	$1,480
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$2,090**

■ The plan's overall deductible	$600
■ Specialist copayment	$30
■ 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	$600
Copayments	$880
Coinsurance	$246
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,726**

■ The plan's overall deductible	$600
■ Specialist copayment	$30
■ Hospital (facility) coinsurance	20%
■ Other copayment	$0

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	$600
Copayments	$180
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$880**

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