BluePreferred
Essential 20 Plan

PERDUE FARMS, INC.

Summary of Benefits

Services	In-Network You Pay[1,2]	Out-of-Network You Pay[1,3]
	Certain services require preauthorization. The failure to obtain pre-authorization will generally result in higher costs to you. Please see the Evidence of Coverage.	
	Visit www.carefirst.com/doctor to locate providers	
FIRSTHELP—24/7 NURSE ADVICE LINE		
Free advice from a registered nurse. Visit **www.carefirst.com/needcare** to learn more about your options for care.	When your doctor is not available, call FirstHelp at 800-535-9700 to speak with a registered nurse about your health questions and treatment options.	
ANNUAL DEDUCTIBLE (Benefit period)[4]		
Individual and Family	$1,200 Individual/$2,400 Family	$2,400 Individual/$4,800 Family
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)[5]		
Medical and Prescription Drug	$6,000 Individual/$12,000 Family	$12,000 Individual/$24,000 Family
LIFETIME MAXIMUM BENEFIT		
Lifetime Maximum	None	None
PREVENTIVE SERVICES		
Well-Child Care (including exams & immunizations)	No charge*	Deductible, then 30% of Allowed Benefit
Adult Physical Examination (including routine GYN visit)	No charge*	Deductible, then 30% of Allowed Benefit
Breast Cancer Screening	No charge*	Deductible, then 30% of Allowed Benefit
Pap Test	No charge*	Deductible, then 30% of Allowed Benefit
Prostate Cancer Screening	No charge*	Deductible, then 30% of Allowed Benefit
Colorectal Cancer Screening	No charge*	Deductible, then 30% of Allowed Benefit
OFFICE VISITS, LABS AND TESTING		
Office Visits for Illness	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Imaging (MRA/MRS, MRI, PET & CAT scans) (Office)	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Lab (Office)	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
X-ray (Office)	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Allergy Testing	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Allergy Shots	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Physical, Speech and Occupational Therapy (limited to 25 visits per benefit period)	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Chiropractic (limited to 25 visits per benefit period)	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Acupuncture	Not covered (except when approved or authorized by Plan when used for anesthesia)	Not covered (except when approved or authorized by Plan when used for anesthesia)
EMERGENCY SERVICES		
Urgent Care Center—Non-Emergency Services	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Urgent Care Center—Medical Emergency Services	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Emergency Room—Facility Services **(for non-emergency services)**	Deductible, then 50% of Allowed Benefit, plus $100 copay for non-emergency services	
Emergency Room—Facility Services	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
Emergency Room—Physician Services **(for non-emergency services)**	Deductible, then 50% of Allowed Benefit for non-emergency services	
Emergency Room—Physician Services	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
Ambulance (if medically necessary)	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit

Services	In-Network You Pay[1,2]	Out-of-Network You Pay[1,3]
HOSPITALIZATION (Members are responsible for applicable physician and facility fees)		
Outpatient Facility Services—Surgery	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Outpatient Facility Services—Non-surgery	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Outpatient Physician Services—Surgery	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Outpatient Physician Services—Non-surgery	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Inpatient Facility Services	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Inpatient Physician Services	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
HOSPITAL ALTERNATIVES		
Home Health Care (limited to 20 visits/benefit period)	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Hospice (limited to 240 days)	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
Skilled Nursing & Inpatient Rehabilitation Facility (limited to 60 days/benefit period)[6]	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
MATERNITY		
Preventive Prenatal and Postnatal Office Visits	No charge*	Deductible, then 30% of Allowed Benefit
Delivery and Facility Services	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Nursery Care of Newborn	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
MENTAL HEALTH AND SUBSTANCE ABUSE (Members are responsible for applicable physician and facility fees)		
Inpatient Facility Services	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Inpatient Physician Services	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Outpatient Facility Services	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Outpatient Physician Services	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Office Visits	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Medication Management	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
MEDICAL DEVICES AND SUPPLIES		
Durable Medical Equipment	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit

Benefits for pharmacy dispensed prescription drugs are not available under the above stated BluePreferred coverage. However, the Group may provide coverage for prescription drug benefits under a separate plan from a third party insurer. Please contact the Group for further details.

Note: Allowed Benefit is the fee that participating providers in the network have agreed to accept for a particular service. The participating provider cannot charge the member more than this amount for any covered service. Example: Dr. Carson charges $100 to see a sick patient. To be part of CareFirst's network, he has agreed to accept $50 for the visit. The member will pay their copay/coinsurance and deductible (if applicable) and CareFirst will pay the remaining amount up to $50.

* No copayment or coinsurance.

[1] When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider.

[2] In-network: When covered services are rendered by a provider in the Preferred Provider network, care is reimbursed at the in-network level. In-network coinsurances are based on a percentage of the Allowed Benefit. The Allowed Benefit is generally the contracted rates or fee schedules that Preferred Providers have agreed to accept as payment for covered services. These payments are established by CareFirst BlueCross BlueShield (CareFirst), however, in certain circumstances, the Allowed Benefit for a Preferred Provider may be established by law.

[3] Out-of-network: When covered services are rendered by a provider not in the Preferred Provider network, care is reimbursed as out-of-network. Out-of-network coinsurances are based on a percentage of the Allowed Benefit. The Allowed Benefit is generally the contracted rates or fee schedules that Preferred Providers have agreed to accept as payment of covered services. These payments are established by CareFirst, however, in certain circumstances, the Allowed Benefit for an out-of-network provider may be established by law. When services are rendered by Non-Preferred Providers, charges in excess of the Allowed Benefit are the member's responsibility.

[4] For family coverage only: When one family member meets the individual deductible, they can start receiving benefits. Each family member cannot contribute more than the individual deductible amount. The family deductible must be met before the remaining family members can start receiving benefits.

[5] For Family coverage only: When one family member meets the individual out-of-pocket maximum, their services will be covered at 100% up to the Allowed Benefit. Each family member cannot contribute more than the individual out-of-pocket maximum amount. The family out-of-pocket maximum must be met before the services for all remaining family members will be covered at 100% up to the Allowed Benefit. Coinsurance amounts that you pay for services from an out-of-network provider (except for emergency room and ambulance services) are not included in your Annual Out-of-Pocket Maximum.

[6] An inpatient admission at a Skilled Nursing Facility and/or an Inpatient Rehabilitation Facility must be within 14 days of a hospital confinement of at least 3 days.

Not all services and procedures are covered by your benefits contract. This summary is for comparison purposes only and does not create rights not given through the benefit plan.

The benefits described are issued under form numbers: CFMI/51+/GC (R. 1/13); CFMI/51+/EOC (4/09); CFMI/DOL APPEAL (R. 9/11); CFMI/51+/DOCS (4/09); CFMI/51+/PPO SOB (4/09); CFMI/VISION RIDER (10/11); CFMI/51+/RX (R. 7/12); CFMI/51+/ELIG (R. 1/10) and any amendments. MD/CF/GC (R. 1/13); MD/BP/EOC (10/07); MD/GHMSI/DOL APPEAL (R. 9/11); MD/BP/DOCS (10/07); MD/CF/BP/SOB (R. 4/08); MD/CF/ATTC (R. 7/09); MD/CF/RX (R. 7/12) and any amendments.