Medical Plan Details

Percentage amounts display what the plan pays.

FOSTER FARMS HEALTH SAVINGS PLAN		
If you enroll in this plan, Foster Farms will open a Health Savings Account (HSA) on your behalf and contribute dollars to this account (see the Benefits Guide for more information). Please note that this is a High Deductible Health Plan – until the deductible is met, the plan only pays for preventive medical care and preventive generic prescription drugs.		
Coverage Tier	**Foster Farms Annual HSA 'Seed' Contribution**	**Employee Annual HSA Contribution Limit**
Employee Only	$500	$2,850
Employee + Spouse or Child	$1,000	$5,750
Family	$1,500	$5,250
Note: IRS regulations allow an Employee of 55 or older an additional $1,000 in contributions under the 'Catch-up' rule.		
Specific Covered Treatments	**In-Network**	**Out-Of-Network**
Preventive Care	100% covered	50%* covered
Teladoc Visits (phone/mobile/video)	$10	$10
Primary Care Physician / Specialty Care Office Visit	70%*	50%*
Inpatient / Outpatient Hospital Services	70%*	50%*
Emergency Room for true emergent care	70%*	70%*
Urgent Care Center	70%*	50%*
Ambulance	70%*	70%*
Inpatient / Outpatient Surgery & Anesthesia	70%*	50%*
Outpatient Diagnostic (X-Ray & Laboratory Services)	70%*	50%*
Maternity – Prenatal and Postnatal Care	100% covered	50%*
Maternity – Inpatient Care	70%*	50%*
Infertility Services	70%* ($15,000 lifetime limit)	Not covered
Physical Therapy (20 visit limit)	70%*	50%*
Chiropractic Care & Acupuncture Note: *Annual Maximums*	70%* *(24 visits)*	50%* *($250 individual / $750 family)*
Nutritional Counseling (6 visit limit)	100% covered	100% covered
Skilled Nursing Facility (100 days per disability)	70%*	50%*
Home Health Care (60 visit limit)	70%*	50%*
Private Duty Nursing & Hospice Care	70%*	50%*
Durable Medical Equipment & Prosthetics	70%*	50%*
Occupational Therapy / Speech Therapy	70%*	50%*
Treatment of Mental Health & Substance Abuse	70%*	50%*
All Other Covered Expenses	70%*	50%*
*Deductible Applies		
See the detailed Benefit Schedule for other conditions, limits, and exclusions. **Call 1-855-550-3744 for more information**.		

Health Savings Plan – Prescription Drugs	**Pharmacy**	**Mail Order**
Non-Preventive Generic Drug Copay	70% after deductible	70% after deductible
Formulary Brand Drug Copay	70% after deductible	70% after deductible
Non-Formulary Drug Copay	70% after deductible	70% after deductible
Preventive Generic Drug Benefit *(Anticonvulsants, Antiarrhythmics, High Cholesterol, Diabetes, High Blood Pressure, Antidepressants & more)*	$0	$0
Maximum Supply	34 days	90 days
If a formulary or non-formulary drug is dispensed, and a generic equivalent is available, the covered person must pay the difference between the cost of the formulary or non-formulary drug and the generic equivalent, plus the generic copay.		

PREVENTIVE PPO PLAN		
Please note that copays do not apply towards the annual medical deductible.		
Specific Covered Treatments	**In-Network**	**Out-Of-Network**
Preventive Care	100% covered	50%* covered
Teladoc Visits (phone/mobile/video)	$10	$10
Primary Care Physician Office Visit	$40 copay (not including lab/x-rays)	50%*
Specialty Care Physician Office Visit	80%*	50%*
Inpatient / Outpatient Hospital Services	80%*	50%*
Emergency Room for true emergent care	80%*	80%*
Urgent Care Center	80%*	50%*
Ambulance	80%*	80%*
Inpatient / Outpatient Surgery & Anesthesia	80%*	50%*
Outpatient Diagnostic (X-Ray & Laboratory Services)	80%*	50%*
Maternity – Prenatal and Postnatal Care	100% covered	50%*
Maternity – Inpatient Care	80%*	50%*
Infertility Services	80%* ($15,000 lifetime limit)	Not covered
Physical Therapy (20 visit limit)	80%*	50%*
Chiropractic Care & Acupuncture Note: *Annual Maximums*	80%* *(24 visits)*	50%* *($250 individual / $750 family)*
Nutritional Counseling (6 visit limit)	100% covered	100% covered
Skilled Nursing Facility (100 days per disability)	80%*	50%*
Home Health Care (60 visit limit)	80%*	50%*
Private Duty Nursing & Hospice Care	80%*	50%*
Durable Medical Equipment & Prosthetics	80%*	50%*
Medically Necessary Occupational / Speech Therapy	80%*	50%*
Treatment of Mental Health & Substance Abuse (Inpatient)	80%*	50%*
Treatment of Mental Health & Substance Abuse (Outpatient)	$40 copay	50%*
All Other Covered Expenses	80%*	50%*
*Deductible Applies		
See the detailed Benefit Schedule for other conditions, limits, and exclusions. **Call 1-855-550-3744 for more information.**		

Preventive PPO Plan - Prescription Drugs	**Pharmacy**	**Mail Order or 90 Day Supply at Pharmacy**
Generic Drug Copay	$10	$20
Formulary Drug Copay	$40	$80
Non-Formulary Drug Copay	$75	$150
Diabetic Drugs and Supplies, Asthma, Blood Pressure, Heart & Cholesterol Drugs	$10	$0
Maximum Supply	34 days	90 days
If a formulary or non-formulary drug is dispensed, and a generic equivalent is available, the covered person must pay the difference between the cost of the formulary or non-formulary drug and the generic equivalent, plus the generic copay.		