Perdue Farms, Inc.
BluePreferred Advantage 10 Plan

Coverage Period: 01/01/2024 – 12/31/2024

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/$1,500 family; Out-of-Network: $1,500 individual/$3,000 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 member(s) on the plan, each family member may need to meet their own individual deductible, OR all family members may combine to meet the overall family deductible before the plan begins to pay, depending upon plan coverage. Please refer to your contract for further details.
Are there services covered before you meet your deductible?	Yes, all In-Network preventive care services, as well as the following (non-hospital facilities only, when applicable): Primary care, Specialist, Retail health, Diagnostic Test, Prescription drugs, Outpatient surgery, Urgent Care, Mental health office visit, Home health care and Rehabilitation Services.	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?	Medical and Prescription Drug combined: In-Network: $5,000 individual/$10,000 family; Out-of-Network: $10,000 individual/$17,000 family.	The out-of-pocket limit is the most you could pay in a plan year for covered services. If you have other family member(s) on the plan, each family member may need to meet their own out-of-pocket limits, OR all family members may combine to meet the overall family out-of-pocket limit, depending upon plan coverage. Please refer to your contract for further details.

What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, copayments for certain services, and penalties for failure to obtain pre-authorization for services. Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the out-of-pocket limit. These drugs (which may be reimbursed by the manufacturer at no cost to you if you participate in the PrudentRx specialty drug program) will not be applied towards satisfying your out of pocket limit.	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 855-258-6518 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 10% of Allowed Benefit	Provider & Hospital Facility: Deductible, then 30% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply.
	Specialist visit	Provider: $50 copay per visit Hospital Facility: Deductible, then 10% of Allowed Benefit	Provider & Hospital Facility: Deductible, then 30% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply.
	Retail health clinic	$30 copay per visit	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. Please see your contract.
If you have a test	Diagnostic test (x-ray, blood work)	Non-Hospital: $30 PCP/$50 Specialist copay per visit Hospital: Deductible, then 10% of Allowed Benefit	Non-Hospital & Hospital: Deductible, then 30% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply.
	Imaging (CT/PET scans, MRIs)	Non-Hospital: $30 PCP/$50 Specialist copay per visit Hospital: Deductible, then 10% of Allowed Benefit	Non-Hospital & Hospital: Deductible, then 30% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply.

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.carefirst.com rxgroup	Generic non-Specialty drugs	Retail: $10 copay Mail Order: $20 copay	Not Covered	Drugs not listed on the formulary are not covered. Non-Specialty drugs are available for up to a 90-day supply at Retail or through the CVS Mail Order service with a Retail Copay applying for up to a 30-day supply and a Mail Order Copay applying for 31-90 day supply. Maintenance medications can be filled two times at any retail pharmacy location before being required to be filled at CVS or Walgreens retail or CVS mail service. All specialty drugs covered under the PrudentRx manufacturer co-pay assistance program ("PrudentRx Specialty Drugs") are subject to 30% coinsurance if you do not participate in the program; if you do participate in the PrudentRx specialty drug program, you can get all of your specialty drugs at no cost to you. Specialty drugs not available to be dispensed by a CVS Exclusive Specialty Pharmacy will follow the regular specialty drug benefit. 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: $30 copay Mail Order: $60 copay	Not Covered	
	Generic Specialty drugs	Retail & Mail Order: $40 copay	Not Covered	
	Preferred brand Specialty drugs	Retail & Mail Order: $120 copay	Not Covered	
	Insulin, syringes, and diabetic supplies	Retail copay applies to both Retail and Mail Order insulin, syringes, and diabetic supplies.	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Non-Hospital: $100 copay per visit Hospital: Deductible, then 10% of Allowed Benefit	Non-Hospital & Hospital: Deductible, then 30% of Allowed Benefit	None
	Physician/surgeon fees	Deductible, then 10% 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)	
If you need immediate medical attention	Emergency room care	Deductible, then $100 copay per visit, then 10% of Allowed Benefit	Paid As In- Network	Limited to Emergency Services or unexpected, urgently required services. Additional professional charges may apply. For other services, you pay Deductible, then $100 copay, then 50% of Allowed Benefit. Copay waived if admitted.
	Emergency medical transportation	Deductible, then 10% of Allowed Benefit	Paid As In- Network	None
	Urgent care	$30 copay per visit	Deductible, then 30% of Allowed Benefit	Limited to unexpected, urgently required services.
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Prior authorization is required. Out-of-Network: Without prior authorization, the Allowed Benefit is reduced to 50%.
	Physician/surgeon fees	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visits: $30 copay per visit Hospital Facility: Deductible, then 10% of Allowed Benefit	Office Visit & Hospital Facility: Deductible, then 30% of Allowed Benefit	For treatment at an Outpatient Hospital Facility, additional charges may apply.
	Inpatient services	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Prior authorization is required; Out-of-Network: Without prior authorization, the Allowed Benefit is reduced to 50%. Additional professional charges may apply
If you are pregnant	Office visits	No Charge	Deductible, then 30% of Allowed Benefit	"No Charge" applies to routine pre/postnatal office visits only. For non-routine obstetrical care or complications of pregnancy, cost sharing may apply.
	Childbirth/delivery professional services	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Childbirth/delivery facility services	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Prior authorization is required; Out-of-Network: Without prior authorization, the Allowed Benefit is reduced to 50%. Additional professional charges may apply.

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 help recovering or have other special health needs	Home health care	No Charge	Deductible, then 30% of Allowed Benefit	Prior authorization is required. Treatment plan must be approved before benefits will be paid. Benefits are limited to 20 visits per benefit period.
	Rehabilitation services	Office Visit: $50 copay per visit Hospital Facility: Deductible, then 10% of Allowed Benefit	Office Visit & Hospital Facility: Deductible, then 30% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply. Benefits for Speech, Physical and Occupational Therapies are limited to 100 days combined per benefit period.
	Habilitation services	Office Visit: $50 copay per visit Hospital Facility: Deductible, then 10% of Allowed Benefit	Office Visit & Hospital Facility: Deductible, then 30% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply. Benefits for Speech, Physical and Occupational Therapies are limited to 100 days combined per Benefit Period.
	Skilled nursing care	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Prior authorization is required. Out-of-Network Skilled Nursing Facility: Without prior authorization, the Allowed Benefit is reduced by 50%. Benefits are limited to 60 days per Benefit Period combined with inpatient rehabilitation. Admission must be within 14 days of a hospital confinement of at least 3 days. Outpatient Private Duty Nursing: Prior authorization is required. Benefits are limited to 20 days per Benefit Period.
	Durable medical equipment	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Hospice services	Deductible, then 10% of Allowed Benefit	Paid As In- Network	Prior authorization is required. Hospice Maximum: Benefits are limited to 180 days per benefit period. Respite Care: Benefits are limited to 14 days Bereavement: Benefits are limited to 3 sessions within one year of a person's death. Family Counseling: Applies to the Hospice Maximum.
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)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine eye care
- 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**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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，请拨打这个号码 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.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$600**
- **Specialist *Copayment*** **$50**
- **Hospital (facility) *Coinsurance*** **10%**
- **Other *Copayment*** **$30**

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$600
Copayments	$150
Coinsurance	$850
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$1,610**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$600**
- **Specialist *Copayment*** **$50**
- **Hospital (facility) *Coinsurance*** **10%**
- **Other *Coinsurance*** **10%**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$600
Copayments	$690
Coinsurance	$62
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,352**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$600**
- **Specialist *Copayment*** **$50**
- **Hospital (facility) *Copayment*** **$100**
- **Other *Copayment*** **$30**

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$600
Copayments	$470
Coinsurance	$84
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,154**

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

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