BluePreferred Advantage 10 Plan Summary of Benefits

Perdue Farms Inc.

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 **carefirst.com/perdue** to locate providers	
24-HOUR NURSE ADVICE LINE		
Free advice from a registered nurse. Visit **carefirst.com/perdue** to learn more about your options for care.	When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health questions and treatment options.	
ANNUAL MEDICAL DEDUCTIBLE (Benefit period)[4] (In-network and Out-of-network combined)		
Medical	$600 Individual/$1,500 Family	$1,500 Individual/$3,000 Family
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)[5] (In-network and Out-of-network combined)		
Medical and Prescription Drug[6]	$5,000 Individual/$10,000 Family	$10,000 Individual/$17,000 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	PCP—$30 copay Video Visit—No charge* Specialist—$50 copay	PCP—Deductible, then 30% of Allowed Benefit Specialist—Deductible, then 30% of Allowed Benefit
Imaging (MRA/MRS, MRI, PET & CAT scans), Lab & X-Ray	Outpatient Facility & Outpatient Physician — Deductible, then 10% of Allowed Benefit; Office— $30 PCP/$50 Specialist	Deductible, then 30% of Allowed Benefit
Allergy Testing & Allergy Shots	$30 PCP/$50 Specialist copay	Deductible, then 30% of Allowed Benefit
Physical, Speech and Occupational Therapy (limited to 100 combined visits per benefit period)	$50 copay	Deductible, then 30% of Allowed Benefit
Chiropractic (limited to 25 visits per benefit period)	$50 copay	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	$30 copay, not subject to the deductible	Deductible, then 30% of Allowed Benefit
Urgent Care Center—Medical Emergency Services	$30 copay, not subject to the deductible	Deductible, then 30% of Allowed Benefit
Emergency Room—Facility & Physician Services (for non-emergency services)	$100 copay, then 50% of Allowed Benefit after deductible (copay waived if admitted)	
Emergency Room—Facility & Physician Services (medical emergency services)	$100 copay, then 10% of Allowed Benefit after deductible (copay waived if admitted)	
Ambulance (if medically necessary)	Deductible, then 10% of Allowed Benefit	Deductible, then 10% 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 & Physician Services—Surgery	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Ambulatory Surgical Facility—Surgery	$100 copay	Deductible, then 30% of Allowed Benefit
Outpatient Facility & Physician Services—Non-surgery	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Inpatient Facility Services	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Inpatient Physician Services	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
HOSPITAL ALTERNATIVES		
Home Health Care (limited to 20 visits/benefit period)	No charge*	Deductible, then 30% of Allowed Benefit
Hospice (limited to 180 days)	Deductible, then 10% of Allowed Benefit	Deductible, then 10% of Allowed Benefit
Skilled Nursing & Inpatient Rehabilitation Facility (limited to 60 days/benefit period)[7]	Deductible, then 10% 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 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Nursery Care of Newborn	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
MENTAL HEALTH AND SUBSTANCE USE DISORDER (Members are responsible for applicable physician and facility fees)		
Inpatient Facility Services	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Inpatient Physician Services	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Outpatient Facility Services	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Outpatient Physician Services	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Office Visits	$30 copay	Deductible, then 30% of Allowed Benefit
MEDICAL DEVICES AND SUPPLIES		
Durable Medical Equipment	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit

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 which would otherwise be subject to the deductible. 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 which would otherwise be subject to the deductible. (In-network and Out-of-network combined)

[5] For Family coverage only: When one family member meets the individual out-of-pocket maximum, all 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 all services for all remaining family members will be covered at 100% up to the Allowed Benefit. The out-of-pocket maximum includes deductibles, copays and coinsurance. (In-network and Out-of-network combined)

[6] Plan has an integrated medical and prescription drug out-of-pocket maximum.

[7] 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.

Pharmacy Program Summary of Benefits

Perdue Farms, Inc.—Advantage 10

Formulary 2 with The Advanced Control Specialty Formulary ■ 5-Tier

Plan Feature	Amount You Pay	Description
Deductible	$0	Your plan does not have a deductible.
Out-of-Pocket Maximum (Medical and Pharmacy)	$5,000 Individual/$10,000 Family	If you reach your out-of-pocket maximum, CareFirst will pay 100% of the applicable allowed benefit for most covered services for the remainder of the year. All deductibles, copays, coinsurance and other eligible out-of-pocket costs count toward your out-of-pocket maximum, except balance billed amounts.
Preventive Drugs (up to a 30-day supply)	$0 (not subject to deductible)	Preventive drugs are a prescribed medication or items on CareFirst's Preventive Drug List.*
Generic Drugs (Tier 1) (up to a 30-day supply)	$10	Generic drug are covered at this copay level.
Preferred Brand Drugs (Tier 2) (up to a 30-day supply)	$30	All preferred brand drugs are covered at this copay level.
Non-preferred Brand Drugs (Tier 3) (up to a 30-day supply)	Not covered	All non-preferred brand drugs on this copay level are not on the Preferred Drug List.* Discuss using alternatives with your physician or pharmacist.
Specialty Generic Drugs (up to a 30-day supply)	$40 copay	**Must be filled through Exclusive Specialty Pharmacy Network**.
Preferred Specialty Drugs (Tier 4) (up to a 30-day supply)	$120	**Must be filled through Exclusive Specialty Pharmacy Network**.
Non-preferred Specialty Drugs (Tier 5) (up to a 30-day supply)	Not covered	All non-preferred brand drugs on this copay level are not on the Preferred Specialty Drug List.* Discuss using alternatives with your physician or pharmacist. All non-preferred brand drugs on this copay level are not on the Preferred Specialty Drug List.* Discuss using alternatives with your physician or pharmacist.
Prudent Rx Copay Program (enrollment required)	**$0 with The PrudentRx Copay Program** As part of your prescription plan, The PrudentRx Copay Program allows you to get all of your specialty medications at no cost to you. That means $0 out-of-pocket for any medications on your Specialty Drug List when you fill at a CVS Exclusive Specialty Pharmacy. PrudentRx will work with manufacturers to get copay card assistance[1] and will manage enrollment and renewals on your behalf. Even if there is no copay card program for your medication, your cost will be $0 for as long as you are enrolled in the program. The table below is an example of how the program works.	

Out-of-pocket cost if enrolled in the program	Out-of-pocket cost if not enrolled
Medication cost: $1,000 for a 30-day supply **Copay[2] responsibility (30%): $300** **Your out-of-pocket cost: $0** Amount applied to deductible: $0[3] Amount applied to out-of-pocket maximum: $0	Medication cost: $1,000 for a 30-day supply **Copay responsibility (30%)[2]: $300** **Your out-of-pocket cost: $300** Amount applied to deductible: $300[3] Amount applied to out-of-pocket maximum: $300**

All specialty drugs covered under the PrudentRx manufacturer copay assistance program are subject to 30% coinsurance if you do not participate in the program.

****Please note:** Example assumes the medication is an "essential health benefit," which allows your out-of-pocket cost to apply to your out-of-pocket maximum. Many specialty medications are considered "non-essential health benefits." For medications that are not essential health benefits,[4] amounts paid by you, a manufacturer or a plan sponsor will not apply to your out-of-pocket maximum.[5]

[1] Eligibility for third-party copay assistance program is dependent on the applicable terms and conditions required by that particular program and are subject to change. Copay assistance programs may not be used with any government payor plan.

[2] Copay, copayment or coinsurance means the amount a plan member is required to pay for a prescription in accordance with a Plan, which may be a perentage of the prescription price, a fixed amount or another charge, with the balance, if any, paid by a Plan.

[3] Only amounts paid by the member apply to the deductible. Amounts paid by manufacturers or others are not applied to the deductible.

[4] A self-funded Plan may define the items and services that qualify as "essential health benefits" by referencing any definition authorized by the U.S. Department of Health and Human Services, including any available state benchmark plan. There's an exception process to decide if a medication that's not an "essential health benefit" is medically necessary for a particular plan member.

[5] The out-of-pocket maximum is the total amount you must pay in a plan year for certain covered services called "essential health benefits." Once the specified out-of-pocket limit is reached, your health plan will pay 100 percent of the cost of these covered services. More information on the out-of-pocket limit is available in your plan benefit materials.

Plan Feature	Amount You Pay	Description
Maintenance Drugs (up to a 90-day supply)	**Retail copays:** ▪ Generic: $20 ▪ Preferred Brand: $60 ▪ Non-preferred Brand: not covered	**Non-Maintenance Drugs (Tiers 1 and 2):** Up to a 90-day supply is available for two monthly copays through Mail Service Pharmacy, a CVS Retail pharmacy, or a Walgreens Retail pharmacy.
	Mail order copays: ▪ Generic: $20 ▪ Preferred Brand: $60 ▪ Non-preferred Brand: not covered	

Visit **carefirst.com/rx** *for the most up-to-date drug lists, including the prescription guidelines. Prescription guidelines indicate drugs that require your doctor to obtain prior authorization from CareFirst before they can be filled and drugs that can be filled in limited quantities.*

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Policy Form Numbers: MD/CFBC/RX (R. 1/18) • CFMI/RX (R. 1/18) • CFMI/Matrix/PRESC DRUG (R. 1/18) • MD/CF/RX (R. 1/18)

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