

For Your Health

Good health is essential to a good life. Sodexo’s health plans are designed to keep you feeling your best while helping you and your family manage the costs of medical care. One of the best ways to stay healthy and save money is to take advantage of preventive healthcare. Getting recommended screenings, annual check-ups and immunizations is important to your well-being. Take full advantage of preventive care benefits—many of the medical plans pay 100% of the cost with no copays.

Medical Benefits – PPO		
Plan	Description	
<p>Preferred Provider Organization (PPO) Option provided by the Cigna Open Access Plus/CareLink Network</p> <p><i>Available to employees in the continental United States and Guam</i></p> <p>www.cigna.com/sodexo</p> <p>800 909 2227</p> <p>Plan Administrator Cigna</p> <p>Eligibility All full-time non-temporary salaried employees (class code 1-4) & eligible dependents</p> <p>Waiting Period When you are hired, your benefits will begin the Saturday following your request within a 45-day window. If you are newly eligible, your benefits can be effective on the Saturday following your enrollment within 45 days of becoming eligible.</p> <p>Precertification required for all hospital services</p>	Annual Deductible	In-network: \$500/individual, \$1,500/family Out-of-network: \$1,000/individual, \$3,000/family
	Annual Out-of-Pocket Maximum	In-network: \$5,000/individual Out-of-network: \$10,000/individual
	Preventive Care (routine physical exams, well-baby care, gyn exams, immunizations)	In-network: 100% Out-of-Network: 100% Tobacco cessation program available at no cost to you.
	Doctor Office Visit (primary and specialist)	In-network: \$20 per visit, then 100% Out-of-network: 60% after deductible
	Hospital <ul style="list-style-type: none"> Inpatient (includes maternity admissions) Outpatient Surgery 	In: 70% after deductible. Out: 60% after deductible In/Out: Precertification required In-network: 70% after deductible Out-of-network: 60% after deductible
	Maternity (pre- and postnatal office visits)	In-network: \$20 initial visit, then 100% Out-of-network: 60% after deductible
	Emergency Care (when not followed by admission)	\$75 per ER visit, then 70% after deductible
	Mental Health <ul style="list-style-type: none"> Inpatient Outpatient 	In-network: 70% covered after deductible. Precertification Required Out-of-network: 60% after deductible. Unlimited days Facility In-network: 70% after deductible. Unlimited visits. Out-of-network: 60% covered after deductible. Unlimited visits Office Visit In-network: \$20 per visit. Unlimited visits. Out-of-network: 60% covered after deductible. Unlimited visits

Medical Benefits – PPO continued

Plan	Description																
	<p>Substance Abuse</p> <ul style="list-style-type: none"> Inpatient Outpatient <p>In-network: 70% covered after deductible. Precertification required Out-of-Network: 60% covered after deductible. Unlimited days</p> <p>Facility In-network: 70% after deductible. Unlimited visits. Out-of-network: 60% covered after deductible. Unlimited visits</p> <p>Office Visit In-network: \$20 per visit. Unlimited visits. Out-of-network: 60% covered after deductible. Unlimited visits</p>																
<p>Prescription Drug Benefit</p> <p>www.medco.com 800 903 7968</p> <p>Mandatory Generic Drugs If you purchase brand-name drugs when a generic is available, you pay more.</p> <p>Retail Refill Allowance If you don't use mail order for your long-term medications, you will pay 100% of the cost of the medication after you fill it three times at a retail pharmacy.</p>	<ul style="list-style-type: none"> Retail (for 30-day supply) <table border="1"> <thead> <tr> <th></th> <th>Copay or Coinsurance</th> <th>Minimum</th> <th>Maximum</th> </tr> </thead> <tbody> <tr> <td>Generic</td> <td>\$10</td> <td>N/A</td> <td>N/A</td> </tr> <tr> <td>Brand Name</td> <td>10%</td> <td>\$35</td> <td>\$100</td> </tr> <tr> <td>Non-Formulary Brand Name</td> <td>30%</td> <td>\$50</td> <td>\$150</td> </tr> </tbody> </table>		Copay or Coinsurance	Minimum	Maximum	Generic	\$10	N/A	N/A	Brand Name	10%	\$35	\$100	Non-Formulary Brand Name	30%	\$50	\$150
		Copay or Coinsurance	Minimum	Maximum													
Generic	\$10	N/A	N/A														
Brand Name	10%	\$35	\$100														
Non-Formulary Brand Name	30%	\$50	\$150														
	<ul style="list-style-type: none"> Mail Order (for 90-day supply) <table border="1"> <thead> <tr> <th></th> <th>Copay or Coinsurance</th> <th>Minimum</th> <th>Maximum</th> </tr> </thead> <tbody> <tr> <td>Generic</td> <td>\$20</td> <td>N/A</td> <td>N/A</td> </tr> <tr> <td>Brand Name</td> <td>10%</td> <td>\$87.50</td> <td>\$200</td> </tr> <tr> <td>Non-Formulary Brand Name</td> <td>30%</td> <td>\$125</td> <td>\$300</td> </tr> </tbody> </table>		Copay or Coinsurance	Minimum	Maximum	Generic	\$20	N/A	N/A	Brand Name	10%	\$87.50	\$200	Non-Formulary Brand Name	30%	\$125	\$300
	Copay or Coinsurance	Minimum	Maximum														
Generic	\$20	N/A	N/A														
Brand Name	10%	\$87.50	\$200														
Non-Formulary Brand Name	30%	\$125	\$300														

Medical Benefits – Kaiser Permanente HMO

Plan	Description
<p>www.kaiserpermanente.org</p> <p>Northern and Southern CA – 800 464 4000 Colorado – 800 632 9700 D.C. Metro/MD/VA – 800 777 7902 Georgia – 888 865 5813 Hawaii – 808 948 6372</p>	<p>For Kaiser Permanente Health Maintenance Organization (HMO) information, call Member Services in your region (numbers listed above). HMO eligibility is based on your home ZIP code. Plan designs and benefits vary by geographic location.</p>

Medical Benefits – UnitedHealthcare Health Reimbursement Account (HRA)

Plan	Description	
<p>UnitedHealthcare HRA (Consumer Driven Plan)</p> <p><i>Only available to employees in the continental United States.</i></p> <p>https://www.myuhc.com/groups/sdx</p> <p>800 784 2023</p> <p>Plan Administrator UnitedHealthcare</p> <p>Eligibility All full-time non-temporary salaried employees (class codes 1-4) and eligible dependents.</p> <p>Waiting Period When you are hired, your benefits will begin the Saturday following your request within a 45-day window. If you are newly eligible, your benefits can be effective on the Saturday following your enrollment within 45 days of becoming eligible.</p>	Health Reimbursement Account (HRA) Annual Funding by Sodexo	\$750 employee only, \$1,175 Employee+1, \$1,500 family Rollover available.
	Member Responsibility	\$1,250 employee only, \$1,825 employee+1, \$2,500 family. <i>Only applies if you exhaust HRA.</i>
	Plan Year Deductible (Combination of HRA and Member Responsibility)	\$2,000 employee only, \$3,000 employee+1, \$4,000 family
	Annual Out-of-Pocket Maximum	In-network: \$3,000 employee only, \$6,000 employee+1, \$10,000 family Out-of-network: \$9,000 employee only, \$18,000 employee+1, \$30,000 family
	Doctor Office Visit (primary and specialist)	In-network: HRA pays 100%, then 80% after deductible. Out-of-network: HRA pays 100%, then 60% after deductible.
	Preventive Care (routine physical exams, well-baby care, gyn exams, immunizations)	In/Out-of-network: 100% coverage. Tobacco cessation program available at no cost to you.
	Hospital <ul style="list-style-type: none"> Inpatient (includes maternity admissions) Outpatient Surgery 	In-network: HRA pays 100%, then 80% after deductible. Out-of-network: HRA pays 100%, then 60% after deductible. In-network: HRA pays 100%, then 80% after deductible. Out-of-network: HRA pays 100%, then 60% after deductible.
	Maternity (pre- and postnatal office visits)	In-network: HRA pays 100%, then 80% after deductible. Out-of-network: HRA pays 100%, then 60% after deductible.
	Emergency Care (when not followed by admission)	In/Out: HRA pays 100%, then 80% after deductible.
	Prescription Drug – Retail (30-day supply unless otherwise noted)	In-network: HRA pays 100%, then 80% after deductible. Home delivery available. No formulary.
	Mental Health <ul style="list-style-type: none"> Inpatient Outpatient 	In-network: HRA pays 100%, then 80% after deductible. Out-of-network: HRA pays 100%, then 60% after deductible. Combined with outpatient Substance Abuse. In-network: HRA pays 100%, then 80% after deductible. Out-of-network: HRA pays 100%, then 60% after deductible.
	Substance Abuse <ul style="list-style-type: none"> Inpatient Outpatient 	In-network: HRA pays 100%, then 80% after deductible. Out-of-network: HRA pays 100%, then 60% after deductible. In-network: HRA pays 100%, then 80% after deductible. Out-of-network: HRA pays 100%, then 60% after deductible.

Medical Benefits – Triple-S		
Plan	Description	
<p>Triple-S</p> <p><i>Available to eligible employees in Puerto Rico.</i></p> <p>www.ssspr.com</p> <p>787 774 6060</p> <p>Plan Administrator Triple-S Salud, Inc.</p> <p>Eligibility All full-time, non-temporary salaried employees (class codes 1-4) and eligible dependents.</p> <p>Waiting Period When you are hired, your benefits will begin the Saturday following your request within a 45-day window. If you are newly eligible, your benefits can be effective on the Saturday following your enrollment within 45 days of becoming eligible.</p> <p>Note A dental benefit is included with this plan.</p>	Annual Deductible	\$100 individual/\$300 family
	Annual Out-of-Pocket Maximum	\$2,000 individual/\$6,000 family
	Doctor Office Visit (primary and specialist)	In-network: \$5 per PCP: \$10 specialist visit, then 100% Out-of-network: 80% covered after deductible
	Preventive Care (routine physical exams, well-baby care, gyn exams, immunizations)	In-network: \$5 per PCP: \$10 specialist visit, then 100% Out-of-network: 80% covered after deductible
	Hospital	
	<ul style="list-style-type: none"> Inpatient (includes maternity admissions) 	In-network: \$50 admission, then 100% Out-of-network: 80% covered after deductible
	<ul style="list-style-type: none"> Outpatient Surgery 	In-network: 100% covered Out-of-network: 80% covered after deductible
	Maternity (pre- and postnatal office visits)	In-network: \$5 per PCP: \$10 specialist visit, then 100% Out-of-network: 80% covered after deductible
	Emergency Care (when not followed by admission)	In-network: \$20 per ER visit, then 100% Out-of-network: 80% covered after deductible
	Prescription Drug – Retail (30-day supply unless otherwise noted)	\$5 (generic), \$10 (preferred brand), \$15 (brand name), 20% or \$15 minimum for non-preferred generic or brand name at participating pharmacy. Mail order available. Non-participating pharmacy in Puerto Rico not covered
	Mental Health (inpatient or outpatient)	Cover services rendered in US, emergencies, services offered by non-participating providers Group Therapy: 50% after deductible up to \$30 per visit, Visit limit based on medical recommendation
Substance Abuse (inpatient or outpatient)	Same as Mental Health above	