# FirstFleet, Inc.

## Summary of Benefits

Effective Date: January 1, 2019

HDHP

| Benefit Highlights | In-Network Benefits | Out-of-Network Benefits [1] |
|---|---|---|
| **Annual Deductible** | | |
| Individual | $2,750 | $5,500 |
| Family | $5,500 | $11,000 |
| If more than one person is covered under this group health plan, the family deductible of $5500 with an embedded individual deductible of $2750 for each family member applies. When any family member has incurred $2750 of eligible medical expenses, that family member's deductible is satisfied. A $2750 deductible could still apply to other family members until $5500 in eligible medical expenses has been incurred by all the family members combined. | | |
| **Annual Out-of-Pocket Maximum** | | |
| Individual | $5,500 | $11,000 |
| Family | $11,000 | $22,000 |
| **Lifetime Maximum** | Unlimited | |
| **Dependent Age Limit** | To age 26 | |
| **4th Quarter Deductible Carryover Provision** | Not Included | |
| **Office Visits** | | |
| Office Visits | 80% after Deductible | 60% after Deductible |
| Routine Diagnostic Lab, X-Ray & Injections | 80% after Deductible | 60% after Deductible |
| Advanced Radiological Imaging [2] [4] [6] | 80% after Deductible | 60% after Deductible |
| **Preventive Health Care Services** | | |
| Well Care Services [9] | 100% | 60% after Deductible |
| Annual Well Woman Exam | 100% | 60% after Deductible |
| Annual Mammography Screening | 100% | 60% after Deductible |
| Annual Cervical Cancer Screening | 100% | 60% after Deductible |
| Annual Prostate Cancer Screening | 100% | 60% after Deductible |
| Immunizations | 100% | 60% after Deductible |
| **Services Received at a Facility (includes professional and facility charges)** | | |
| Inpatient Services [2] [4] | 80% after Deductible | 60% after Deductible |
| Outpatient Surgery [3] [4] [5] | 80% after Deductible | 60% after Deductible |
| Routine Diagnostic Services-Outpatient | 80% after Deductible | 60% after Deductible |
| Advanced Radiological Imaging-Outpatient [2] [4] [6] | 80% after Deductible | 60% after Deductible |
| Other Outpatient Services [7] | 80% after Deductible | 60% after Deductible |
| Emergency Care Services | 80% after Deductible | 80% after Deductible |
| **Medical Equipment** | | |
| Durable Medical Equipment | 80% after Deductible | 60% after Deductible |
| Prosthetics | 80% after Deductible | 60% after Deductible |
| Orthotic Appliances | 80% after Deductible | 60% after Deductible |
| **Behavioral Health** | | |
| Inpatient: Unlimited days per annual benefit period | 80% after Deductible | 60% after Deductible |
| Outpatient: Unlimited visits per annual benefit period | 80% after Deductible | 60% after Deductible |
| **Therapeutic Services [8]** | | |
| Therapy (Limited to 20-36 visits per annual benefit period per therapy type) | 80% after Deductible | 60% after Deductible |
| **Skilled Nursing Facility & Rehabilitation Facility Services [2] [4]** | | |
| Limited to 60 days combined | 80% after Deductible | 60% after Deductible |
| **Home Health Services [2]** | | |
| Limited to 60 visits per annual benefit period | 80% after Deductible | 60% after Deductible |
| **Hospice Services** | 80% after Deductible | 60% after Deductible |
| **Ambulance Service** | 80% after Deductible | 80% after Deductible |
| **Retail Prescription (up to 30 days)** | | |
| Non-Preventive (Generic or Brand) | 80% after Deductible | 60% after Deductible |
| Preventive Generic (on PDL)* | $10 Copayment | 60% after Deductible |
| Preventive Preferred Brand (on PDL)* | $35 Copayment | 60% after Deductible |
| Preventive Non-Preferred Brand (on PDL)* | $70 Copayment | 60% after Deductible |
| **Home Delivery/Plus90 Network Options** | | |
| **Prescription (up to 90 days)** | | |
| Non-Preventive (Generic or Brand) | 80% after Deductible | 60% after Deductible |
| Preventive Generic (on PDL)* | $20 Copayment | 60% after Deductible |
| Preventive Preferred Brand (on PDL)* | $70 Copayment | 60% after Deductible |
| Preventive Non-Preferred Brand (on PDL)* | $140 Copayment | 60% after Deductible |

*The copayment feature is only available for Preventive Drugs that are listed in BCBST's Preventive Drug List (PDL.

NOTE: Please see your Summary Plan Description for all details, including plan limits, conditions and exclusions. This is a summary only!

**Notes:**

1. Out-of-network benefit payment based on BlueCross BlueShield of Tennessee maximum allowable charge. You are responsible for paying any amount exceeding the maximum allowable charge.
2. Requires prior authorization.
3. Certain Outpatient Surgeries and/or procedures may require prior authorization.
4. If prior authorization is required, when using network providers outside Tennessee and all out-of-network providers, benefits will be reduced to 50% if prior authorization is not obtained and services are medically necessary. If services are not medically necessary no benefits will be provided.
5. Surgeries include incisions, excisions, biopsies, injection treatments, fracture treatments, applications of casts and splints, sutures, and invasive diagnostic services (e.g., colonoscopy,
6. CAT scans, PET Scans, MRIs, nuclear medicine and other similar technologies.
7. Includes services such as chemotherapy, radiation therapy, and renal dialysis.
8. Physical, speech, manipulative, and occupational therapies are limited to 20 visits per therapy type per annual benefit period. Cardiac and pulmonary rehabilitative therapies are limited to 36 visits per therapy type per annual benefit period.
9. Services include: annual physical, childhood immunizations, recommended adult immunizations, vision and hearing screenings performed by the physician during the preventive health exam.