BlueCross BlueShield of Tennessee

**FirstFleet, Inc.**
**PPO Plan 2**

# PPO Benefits

**Effective: January 1, 2019**

| Benefit Features | Network Providers | Out-of-Network Providers [1] |
|---|---|---|
| **Annual Deductible** | | |
| Individual | $1,750 | $3,500 |
| Family | $3,500 | $7,000 |
| **Annual Out-of-Pocket Maximum Amount** | | |
| Individual | $5,250 | $10,500 |
| Family | $10,500 | $21,000 |
| **Lifetime Maximum** | Unlimited | |
| **Dependent Age Limit** | To age 26 | |
| **4th Quarter Deductible Carryover Provision** | Included | Included |
| **Benefits for Covered Services** | **Network Benefits** | **Out-of-Network Benefits [1]** |
| **Practitioner Office Services** | | |
| Primary Care / Specialist Office Visits | $35/ $50 Copayment | 60% after Deductible |
| Routine Diagnostic Lab, X-Ray, & Injections | No Additional Copayment | 60% after Deductible |
| Advanced Radiological Imaging [2,4] | 80% after Deductible | 60% after Deductible |
| Provider-Administered Specialty Drugs (7) | $240 Copayment | 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] | 80% after Deductible | 60% after Deductible |
| Outpatient Surgery [3] | 80% after Deductible | 60% after Deductible |
| Routine Diagnostic Services-Outpatient | 100% | 60% after Deductible |
| Advanced Radiological Imaging-Outpatient [2,4] | 80% after Deductible | 60% after Deductible |
| Provider-Administered Specialty Drugs (7) | $240 Copayment | 60% after Deductible |
| Other Outpatient Services [5] | 80% after Deductible | 60% after Deductible |
| Emergency Care Services | 80% after Deductible | 80% after Deductible |
| **Medical Equipment** | | |
| Durable Medical Equipment, Prosthetic & Orthotic Appliances | 80% after Deductible | 60% after Deductible |
| **Non-Surgical Sleep Apnea Treatment** | 80% | 60% |
| **Therapeutic Services [6]** | | |
| Therapy (Limited to 20 - 36 visits per year per therapy type) | 80% after Deductible | 60% after Deductible |
| **Skilled Nursing Facility & Rehabilitation Facility Services [2]** | | |
| Limited to 100 days combined | 80% after Deductible | 60% after Deductible |
| **Home Health Services [7]** | | |
| Limited to 60 visits per year | 80% after Deductible | 60% after Deductible |
| **Hospice Services** | 100% | 60% after Deductible |
| **Ambulance Service** | 80% after Deductible | 80% after Deductible |
| **Behavioral Health** | | |
| Inpatient Services [2] | 80% after Deductible | 60% after Deductible |
| Outpatient Services | $35 Copayment | 60% after Deductible |
| **Retail Prescription Copay (up to 30 days)** | | |
| Generic | $10 Copayment | 60% after Deductible |
| Preferred Brand | $40 Copayment | 60% after Deductible |
| Non-Preferred Brand | $80 Copayment | 60% after Deductible |
| **Home Delivery/Plus90 Network Options** | | |
| **Prescription Copayment (up to 90 days)** | | |
| Generic | $20 Copayment | 60% after Deductible |
| Preferred Brand | $80 Copayment | 60% after Deductible |
| Non-Preferred Brand | $160 Copayment | 60% after Deductible |
| **Specialty Drug Copayment** (must use Specialty Pharmacy Network) | 25% (not to exceed $240) | N/A |

**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. Services require prior approval. Benefits will be reduced to 50% for services received from network providers outside Tennessee and all out-of-network providers when prior approval is not obtained.
3. Surgeries include invasive diagnostic procedures such as colonoscopy and sigmoidoscopy.
4. CAT scans, MRIs, nuclear medicine and other similar technologies.
5. Includes services such as chemotherapy, radiation therapy, infusions, and renal dialysis
6. Physical, speech, manipulative, and occupational therapies are limited to 20 visits per therapy type per year. Cardiac and pulmonary rehabilitative therapies are limited to 36 vi
7. Requires prior approval.
8. Services include: annual physical, childhood immunizations, recommended adult immunizations, vision and hearing screenings performed by the physician during the preventi