Delta Foremost Chemical Corp.

Benefit Summary

PLAN 2

BlueCross BlueShield of Tennessee
An Independent Licensee of the BlueCross BlueShield Association

Effective Date:
01/01/2023 Network:
Network S - TN
Blue Card PPO - Non TN

PPO

Benefit Plan Features	Your Cost In-Network	Your Cost Out-Of-Network [1]
Annual Deductible		
Individual/Family	$2,500 / $5,000	$5,000 / $10,000
Annual Out-of-Pocket Maximum		
(includes copays, coinsurance and deductibles)		
Individual/Family	$5,000 / $10,000	$15,000 / $30,000
Covered Services		
Preventive Care Services [13]	Covered at 100%	40% after Deductible
Practitioner Office Services		
Primary Care Office Visits	20% after Deductible	40% after Deductible
Specialist Office Visits	20% after Deductible	40% after Deductible
Office Surgery [4, 5, 6]	20% after Deductible	40% after Deductible
Routine Diagnostic Lab, X-Ray & Injections	20% after Deductible	40% after Deductible
Advanced Radiological Imaging [3, 5, 7]	20% after Deductible	40% after Deductible
Teladoc Health Virtual Care	$10 Copay	Not Covered
Services Received at a Facility		
(includes professional and facility charges)		
Inpatient Services [3, 5]	20% after Deductible	40% after Deductible
Outpatient Surgery [4, 5, 6]	20% after Deductible	40% after Deductible
Routine Diagnostic Services-Outpatient	20% after Deductible	40% after Deductible
Advanced Radiological Imaging-Outpatient [3, 5, 7]	20% after Deductible	40% after Deductible
Other Outpatient Services [8]	20% after Deductible	40% after Deductible
Urgent Care Center Services	20% after Deductible	40% after Deductible
Emergency Care Services [10]	20% after Deductible	20% after Deductible
Emergency Care Advanced Radiological Imaging [7]	20% after Deductible	20% after Deductible
Skilled Nursing & Rehabilitation Facility Services [3, 5]		
Limited to 60 days combined per annual benefit period	20% after Deductible	40% after Deductible
Medical Equipment Services [4, 5]		
Durable Medical Equipment	20% after Deductible	40% after Deductible
Prosthetics or Orthotics	20% after Deductible	40% after Deductible
Hearing Aids (under age 18) [21]	20% after Deductible	40% after Deductible

Covered Services (continued)		
Behavioral Health Services		
(Unlimited days per calendar annual benefit period)		
Inpatient [3, 5]	20% after Deductible	40% after Deductible
Outpatient [14]	20% after Deductible	40% after Deductible
Therapeutic Services [4, 5, 9]	20% after Deductible	40% after Deductible
Home Health Services [4, 5, 9]	20% after Deductible	40% after Deductible
Hospice Services [5, 22]	Covered at 100%	40% after Deductible
Ambulance Services[4]	20% after Deductible	20% after Deductible
Prescription Drugs [4, 11, 12, 20]		
Prescription Contraceptives [16]	Covered at 100%	40% after Deductible
Retail Network, Plus90 or Home Delivery Network [15]		
Preferred Generic	$10 Copay	40% after Deductible
Non-Preferred Generic	$20 Copay	40% after Deductible
Preferred Brand	$35 Copay	40% after Deductible
Non-Preferred Brand	$50 Copay	40% after Deductible
Self-administered Specialty Drugs [17, 23]		
Specialty Pharmacy Network		
Preferred Specialty	50%	Not Covered
Non-Preferred Specialty	50%	Not Covered
Provider-Administered Specialty Drugs [4,17]		
Specialty Pharmacy Network	50%	Not Covered