Delta Foremost Chemical Corp.

Benefit Summary

PLAN 3

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	$1,500 / $3,000	$3,000 / $6,000
Annual Out-of-Pocket Maximum		
(includes copays, coinsurance and deductibles)		
Individual/Family	$4,000 / $8,000	$12,000 / $24,000
Covered Services		
Preventive Care Services [13]	Covered at 100%	40% after Deductible
Practitioner Office Services		
Primary Care Office Visits [2]	$25 Copay	40% after Deductible
Specialist Office Visits	$50 Copay	40% after Deductible
Office Surgery [4, 5, 6]	20% after Deductible	40% after Deductible
Routine Diagnostic Lab, X-Ray & Injections	$25 Copay	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	$25 Copay	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	$50 Copay	40% after Deductible
Emergency Care Services [10]	$250 Copay	$250 Copay
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] Outpatient [14]	 20% after Deductible $25 Copay per visit	 40% 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 Non-Preferred Generic Preferred Brand Non-Preferred Brand	 $10 Copay $20 Copay $35 Copay $50 Copay	 40% after Deductible 40% after Deductible 40% after Deductible 40% after Deductible
Self-administered Specialty Drugs [17, 23] Specialty Pharmacy Network Preferred Specialty Non-Preferred Specialty	 50% 50%	 Not Covered Not Covered
Provider-Administered Specialty Drugs [4,17] Specialty Pharmacy Network	 50%	 Not Covered