Delta Foremost®

Employee Benefits Details & Descriptions

2023

Delta Foremost Chemical is proud to present its insurance and retirement benefits to our valued employees.

Carefully review this information and select which insurance options are best suited for you and your family. You may select as many options as you wish.
Enrollment is limited to the open enrollment period for existing employees. New employees coverage begins on 1st of the month after date of hire. Once you are enrolled you may not drop or change your insurance until the next open enrollment period.

Waiting Periods for Eligibility for Insurance Coverage		
Type of Insurance	**Waiting Periods**	**Open Enrollment Period**
Health Insurance	**Eligibility begins 1st of month after hire date**	**January 1**
Dental	**Eligibility begins 1st of month after hire date**	**January 1**
Vision	**Eligibility begins 1st of month after hire date**	**January 1**
Fixed Premium & Voluntary Life	**Eligibility begins 1st of month after hire date**	**Hire Date Only**
Disability	**Eligibility begins 1st of month after hire date**	**Hire Date Only**
401k	**Eligibility begins 1st of month after 6 months**	**Monthly**

Delta Foremost has teamed up with Bluecross Bluesheild to provide our our employees with health care insurance.

The plan year starts January 1, 2023 and runs to December 31, 2023.

There are three Health Care Levels being offered. Each has a different deductible, prescription benefits and cost. **Read the information in this pamphlet carefully** in order to make the best selection for you and your family.

- Plan 1 - Description of Health Care ($4000 Deductible)
- Plan 2 - Description of Health Care ($2500 Deductible)
- Plan 3 - Description of Health Care ($1500 Deductible)
- Guide to using your Pharmacy Benefits
- Virtual visits (Telemedicine)
- Dental, Vision, Life & Disability Benefits
- How to register...go to bcbs.com
- How to find In-Network Physicians: Before you set your card, go to bcbs.com, click on "Find Care". TN Employees will search for "Network S". Non TN Employees will search for "BlueCard PPO Network". After you receive your card, you will be able to register for your member portal.

Delta Foremost Chemical Corp.

Benefit Summary

PLAN 1

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	$4,000 / $8,000	$8,000 / $16,000
Annual Out-of-Pocket Maximum		
(includes copays, coinsurance and deductibles)		
Individual/Family	$6,850 / $13,700	$20,550 / $41,100
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] Outpatient [14]	 20% after Deductible 20% after Deductible	 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	 20% after Deductible 898989 20% after Deductible 20% after Deductible 20% after Deductible	 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	 20% after Deductible 20% after Deductible	 Not Covered Not Covered
Provider-Administered Specialty Drugs [4,17] Specialty Pharmacy Network	 20% after Deductible	 Not Covered

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

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

Blue Cross Blue Shield of Tennessee

COMING JAN. 1, 2023:

Talk to Doctors Anytime You Need Them

Teladoc HEALTH

Use Teladoc™ Health when it's not an emergency, and you can't get to a doctor's office. **It's available 24/7, and you'll typically pay less than you would for a visit to the office or urgent care clinic.**

Teladoc Health can be used for things like:

- Allergies, cold, fever and flu
- Constipation or diarrhea
- Sinus or respiratory issues
- Earaches
- Mental health support
- Urinary tract infections
- Nausea and vomiting
- Pink eye
- Skin conditions (rashes or insect bites)

How do I use Teladoc Health?

You can get started using online video chat or our free BCBSTN app. Just have your Member ID card ready. It's easy to get started. Register by logging in to our BCBSTN app or at **bcbst.com/Teladoc** and choosing **Talk With a Doctor Now**. You can also call **1-800-TELADOC**.

The first time you use Teladoc Health, you'll need to fill out a short medical history survey and create an account. The next time you use it, you can just log in through our app and talk to a doctor in minutes.

Summary of Preventive Care Services Covered at 100%

In-network preventive care services that are covered with no member cost share include, but are not limited to:

- Primary care services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF)
- Immunizations recommended by the Advisory Committee on Immunization Practices that have been adopted by the Centers for Disease Control and Prevention (CDC)
- Bright Futures recommendations for infants, children and adolescents that are supported by the Health Resources and Services Administration (HRSA)
- Preventive care and screening for women as provided in the guidelines supported by HRSA

The following preventive care services are covered (not an all-inclusive list). Coverage of some services may depend on age and/or risk exposure.

All Members:

- One preventive health exam per annual benefit period; more frequent preventive exams are covered for children up to age 3
- All standard immunizations adopted by the CDC
- Screening for colorectal cancer (age 45 – 75), high cholesterol and lipids (age 45 and older for women; age 35 and older for men), high blood pressure, obesity, diabetes and depression (age 12 and older)
- Screening for lung cancer for adults (age 50 - 80) who have a 20 pack-year smoking history and either currently smoke or have quit within the past 15 years, per annual benefit period
- Screening for HIV and certain sexually transmitted diseases and counseling for the prevention of sexually transmitted diseases
- Screening and counseling in primary care setting for alcohol misuse and tobacco use; alcohol misuse and tobacco cessation counseling limited to 8 visits per annual benefit period
- Dietary counseling for adults with hyperlipidemia, hypertension, type 2 diabetes, obesity, coronary artery disease and/or congestive heart failure; limited to 12 visits per annual benefit period
- One retinopathy screening for diabetics per annual benefit period
- Hemoglobin (A1C) testing

Women:

- Well-woman visit, including annual sexually transmitted infection (STI) counseling and annual domestic violence screening & counseling per annual benefit period
- Cervical Cancer Screening per annual benefit period
- Screening of pregnant women for iron deficiency, bacteriuria, hepatitis B virus, Rh factor incompatibility, gestational diabetes
- Breastfeeding support/counseling & supplies, including lactation support services and counseling by a trained provider and one breast pump per pregnancy
- Counseling women at high risk of breast cancer for chemoprevention, including risks and benefits
- Mammography screening (age 40 and older) and genetic counseling and, if indicated after counseling, BRCA testing for BRCA breast cancer gene
- Osteoporosis screening (age 60 and older)
- HPV testing once every 3 years, beginning at age 30
- FDA-approved contraceptive methods and counseling
  Medical plan: Injectable or implantable contraceptives and barrier methods, sterilization for women
  Rx plan: Generic oral & injectable contraceptives, vaginal contraceptive, patch, prescription emergency contraception

Men:

- Prostate cancer screening (age 50 and older)
- One-time abdominal aortic aneurysm screening (age 65 – 75 for men who have ever smoked)

Children:

- Newborn screening for hearing, phenylketonuria (PKU), thyroid disease, sickle cell anemia and cystic fibrosis
- Development delays and autism screening
- Iron deficiency screening
- Vision screening

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your Evidence of Coverage (EOC) defines the full terms and conditions in greater detail. Should any questions arise concerning benefits, the EOC will govern. For a complete list of limitations and exclusions, please refer to your EOC.

Your Guide to Prescription Drug Benefits

2022 Preferred Formulary Guide

of Tennessee

Please see the inside cover for a list of all the plans this formulary applies to. This document contains information about the drugs covered in your prescription drug benefit plan.

Important Contacts

For more information about your prescription drug coverage, call the phone number listed on your BlueCross BlueShield of Tennessee Member ID card. For information about your home delivery prescription, call **1-800-552-8159**.

Visit bcbst.com

- Find a pharmacy in your network
- Look up lower-cost prescription alternatives
- Compare your pricing and options

If You Want Us to Rethink Your Request

You or your doctor may ask to reconsider any of these things:

- A denial of a drug benefit
- Limits on a drug quantity
- The details needed for prior authorization
- Getting a non-covered drug approved

You'll need written reasons from your doctor about why we should rethink your situation.

We look at all reconsiderations on a case-by-case basis. Your Evidence of Coverage or member handbook has details on your rights to file reconsiderations.

Fax all information to **1-888-343-4232**.
Or send a written request to:

Pharmacy Management Reconsiderations
BlueCross BlueShield of Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402-2555

Please provide the following information with your request:

- Patient name and cardholder ID number
- Physician name and phone number
- Drug and diagnosis information

Understanding the Formulary Drug List

This formulary drug list will help you understand the drugs your plan covers. The drugs in this formulary are listed by common categories, then alphabetically. They're placed into cost levels known as tiers. Some drugs have notes with letters next to them. The letters refer to certain pharmacy benefit programs. To make sure that prescriptions are used safely, some drugs have additional requirements you'll need to meet before we can cover your prescription. Those drugs will have an abbreviation next to the drug name to let you and your doctor know there are additional requirements.

For more information on how to fill your prescriptions, please refer to your Evidence of Coverage or member handbook on **bcbst.com** or call the phone number listed on your BlueCross Member ID card.

Abbreviation	Description
ACA	**Affordable Care Act** means drugs with the ACA indicator may be available to you at no out-of-pocket cost depending on your plan. Check your Evidence of Coverage or member handbook for plan details.
LD	**Limited Distribution** means drugs may only be available at certain pharmacies. For more information, please call us at the Member Service number on your Member ID card.
MME	**Morphine Milligram Equivalent** Your plan measures how strong each medicine is compared to morphine and limits the combined total, or MME. Prior authorization is required for members who take greater than 120 mg equivalents of morphine a day. Your doctor must request a coverage review with BlueCross by submitting the request digitally through CoverMyMeds, calling 1-800-924-7141, or faxing 1-888-343-4232.
OTC	**Over-the-counter.** Requires a prescription to be considered eligible for coverage.
PA	**Prior Authorization** may be required for certain drugs. Your doctor must request a coverage review with BlueCross by submitting the request digitally through CoverMyMeds, calling 1-800-924-7141, or faxing 1-888-343-4232.
QL	**Quantity Limit** means you may have coverage for a limited amount of a specific drug.
ST	**Step Therapy** is a prior authorization program that requires you to first try certain drugs to treat your medical condition before we'll cover another drug for that condition. Your doctor must request a coverage review with BlueCross by submitting the request digitally through CoverMyMeds, calling 1-800-924-7141, or faxing 1-888-343-4232. Please refer to the list included on page iv for drugs that require step therapy.

What's a Drug Tier?

Tiers are the different cost levels you pay for a prescription drug. Each tier is assigned a cost (copay, deductible or coinsurance), which your employer or health plan determines. This is how much you will pay when you fill a prescription. If you have a high deductible plan, the tier cost levels may apply once you hit your deductible. Check your Evidence of Coverage or member handbook for plan details.

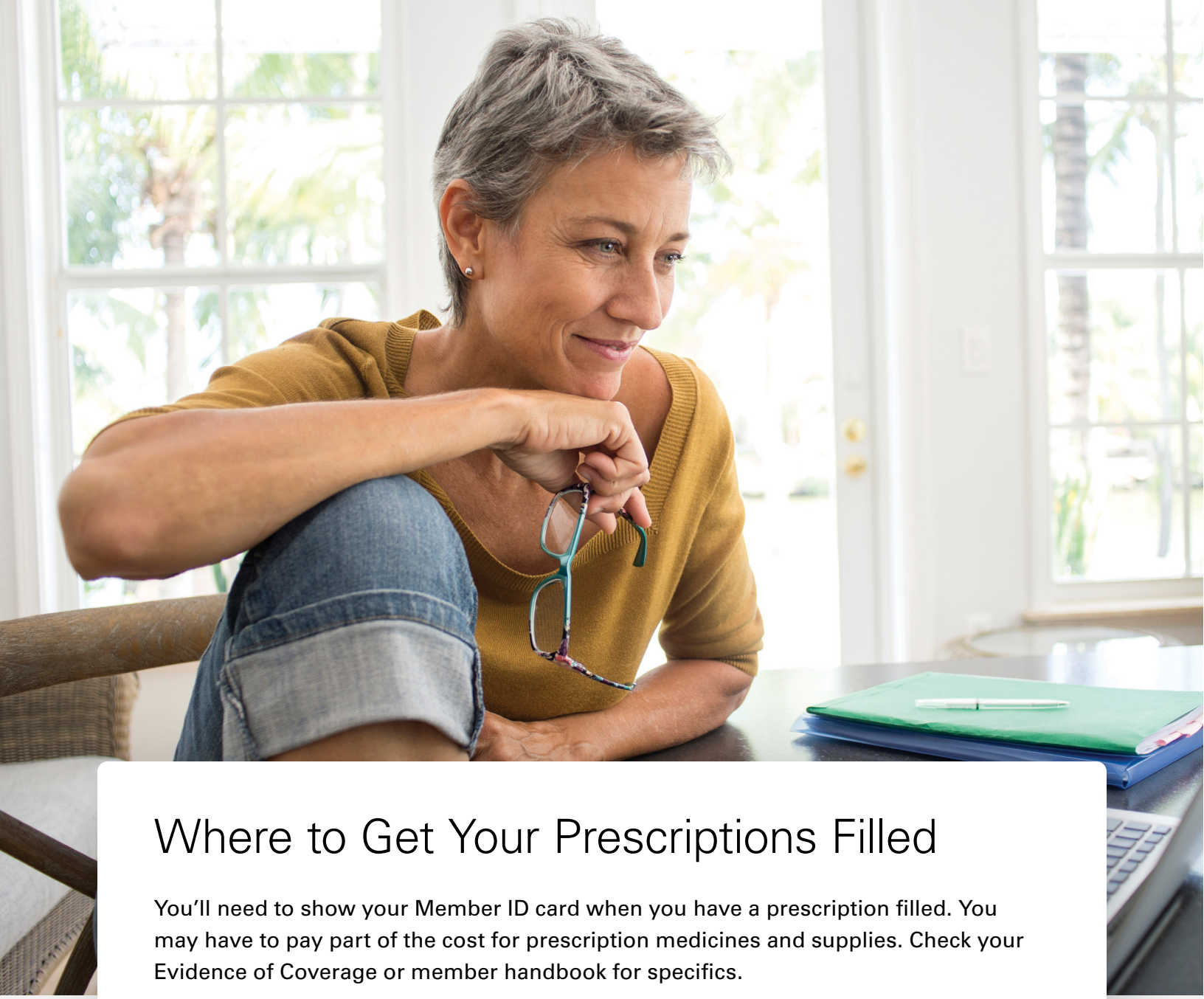
Drug Tiers

Tier 1	Preferred Generic Drugs The most affordable drugs
Tier 2	Non-Preferred Generic Drugs More expensive generic drugs
Tier 3	Preferred Brand Drugs More affordable brand-name drugs
Tier 4	Non-Preferred Brand Drugs More expensive, non-specialty brand drugs
Tier 5	Preferred Specialty Drugs More affordable specialty drugs
Tier 6	Non-Preferred Specialty Drugs The most expensive specialty drugs

Step Therapy Requirements

Step Therapy requires you to first try certain drugs to treat your medical condition before we cover another drug for that condition. This chart lists the drugs that require step therapy before your plan will cover the medication.

Medication(s) Requiring Step Therapy	Step Therapy Requirements
Edarbi **Edarbyclor**	Trial and failure of a generic Angiotensin II Receptor Blocker (ARB), including candesartan, candesartan-hydrochlorothiazide, eprosartan, irbesartan, irbesartan-hydrochlorothiazide, losartan, losartan-hydrochlorothiazide, olmesartan, olmesartan-hydrochlorothiazide, telmisartan, telmisartan - hydrochlorothiazide, valsartan and valsartan-hydrochlorothiazide
Admelog **Admelog SoloStar** **Apidra** **Apidra SoloStar** **Humalog** **Humalog KwikPen** **Humalog Junior KwikPen** **Insulin Lispro** **Insulin Lispro Kwikpen** **Lyumjev** **Lyumjev KwikPen**	Trial and failure of Fiasp, Fiasp FlexTouch, or Novolog
Humulin	Trial and failure of Novolin
Epidiolex	Trial and failure of two anticonvulsant products or one anticonvulsant product specifically indicated for Lennox Gastaut Syndrome or Dravet Syndrome
Pentasa	Trial and failure of generic balsalazide, mesalamine, or sulfasalazine
Briviact	Trial and failure of levetiracetam, levetiracetam ER, Roweepra, Roweepra XR, and Spritam



Where to Get Your Prescriptions Filled

You'll need to show your Member ID card when you have a prescription filled. You may have to pay part of the cost for prescription medicines and supplies. Check your Evidence of Coverage or member handbook for specifics.

Network Pharmacies

Our pharmacy networks include many retail drug store chains and independent pharmacies across the country. If your medication isn't for managing a long-term condition, the prescription is typically written for less than a 30-day supply. (See the Retail 90 and Home Delivery Network sections for information on 90-day supplies).

It's important that you always use an in-network pharmacy. If you don't, you'll have to pay all of the costs for your prescription. If you're outside Tennessee, you can find a pharmacy in our nationwide network. Check your Evidence of Coverage or member handbook for your pharmacy network details.

How to find a network pharmacy:

› Go to **bcbst.com/RXplan**.

- Log in to or create your online account.
- Click on **Find Care & Estimate Costs**.
- Choose your pharmacy network from the **Network** drop-down menu.

Or

› Call us at the Member Service number on the back of your Member ID card.

› You can also find network pharmacies using our free app. Search for "**BCBSTN**" in the App Store® or Google Play®.

Retail 90 Networks

Through Retail 90 Networks you can get up to a 90-day (three-month) supply of your prescriptions.*

› With a three-month supply, you're less likely to miss a dose, and you don't have to refill as often, which can save you time and money.

› If you use a pharmacy that's not part of your Retail 90 Network, you're limited to a 30-day (one-month) supply.

› These networks are made up of some local pharmacies and drug store chains. Ask your pharmacy if they're part of your Retail 90 Network.

Home Delivery

You can sign up for home delivery and have your prescription delivered right to your door. Home Delivery is for prescriptions with a 30-day (one-month) or a 90-day (three-month) supply.* Call **1-800-552-8159** to get started.

With home delivery you get:

› FREE standard shipping**

› Access to a pharmacist 24/7

› Automatic refill reminders so you're less likely to miss a dose

› Extended payment plan available

Specialty Pharmacies

Some serious medical conditions need specialty drugs. They may be given at the doctor's office or at home. Our specialty pharmacies are a special network of vendors, experienced in managing these specialty drugs and supporting you and your doctor. You and your doctor can find a list of specialty pharmacies at **bcbst.com**.

Specialty drugs:

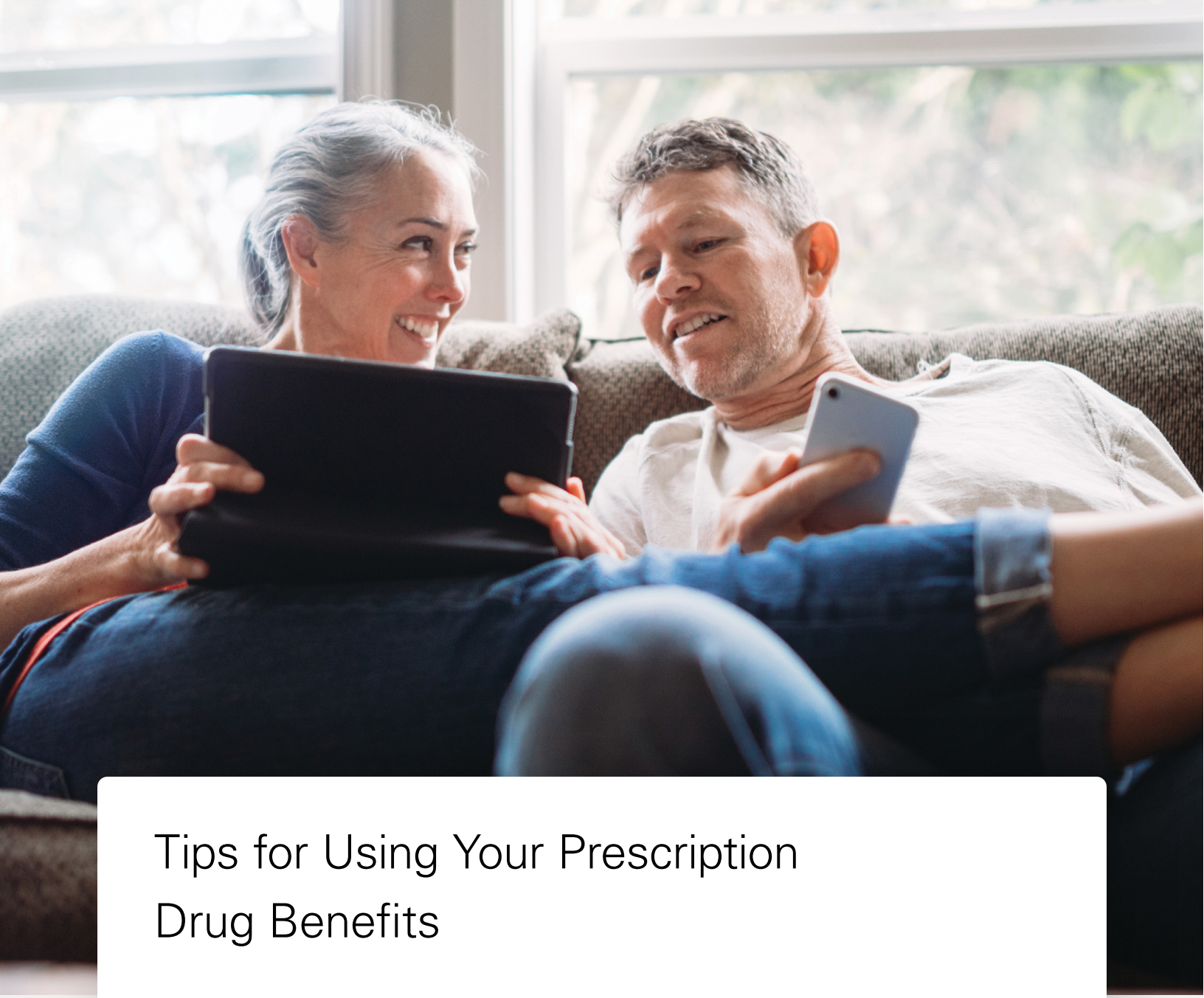
› Usually require a prior authorization

› Usually are limited to a 30-day supply

› Are usually only available from specialty pharmacies in our network. Check your Evidence of Coverage or member handbook for your pharmacy network details.

* Your doctor will need to write your prescription for a 90-day supply.

** Standard shipping costs are included.



Tips for Using Your Prescription Drug Benefits

Talk with your doctor.

Doctors are your partners, so discuss every aspect of your treatment, including the selection of drugs. The more you know, the better choices you can make.

- Ask your doctor to check the list of drugs your plan covers before prescribing a medicine.
- Give your doctor a list of all the medicines you take. Include medicines that don't need a prescription. This helps them choose medicines that work well together.
- Advertising, social media or the internet may not be your best source of information. Discuss all your concerns with your doctor.

Ask for generic drugs.

The U.S. Food and Drug Administration (FDA) requires generic drugs to have the same quality, strength and effectiveness as brand-name drugs.

- Generic drugs work the same as brand name drugs, but cost less.
- Talk to your doctor about the different kinds of generic drugs.
- The formulary drug list has different tiers (levels) of drugs that you can use (see "What's a Drug Tier?" on page iii).
- You pay less for generic drugs almost every time.
- Under most BlueCross plans, if you request a brand name drug that has a generic equivalent, you pay the cost difference between the generic and brand name drug. Check your Evidence of Coverage or member handbook to see if this applies to your plan.

Talk to your pharmacist.

Your pharmacist can answer questions about the drugs you take, help you avoid harmful drug interactions, and help you select appropriate, lower-cost generics and preferred brands whenever available.

- Have all of your family's prescriptions filled at the same pharmacy.
- By knowing all your prescriptions, your pharmacist can make sure all of your drugs work well together. This can help keep you and your family safe.

Use over-the-counter (OTC) medicines to save money.

- OTC medicines are sold without a prescription.
- Some prescription drugs may not be covered under your plan because there is an OTC available that works just as well.
- Don't switch from a prescription drug to an OTC without talking with your doctor.

Be safe with your prescriptions.

- Never share prescription drugs — even if it's for a member of the family.
- Keep all medicines safe from children, out of sight and out of reach. Lock them away, if possible.
- Don't stop using a prescription without talking to the doctor.
- Follow up with the doctor about any side effects.

Some prescriptions need an approval for coverage.

- Some prescriptions require prior authorization or step therapy.
- Some drugs have limits on the amount of them that your plan will pay for.
- Network doctors usually know this and know how to get authorizations. However, you may want to show this formulary drug list to your doctor — especially if you use an out-of-network doctor or a doctor outside Tennessee.

Nondiscrimination Notice

BlueCross BlueShield of Tennessee (BlueCross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BlueCross does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

BlueCross:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.
- Provides free language services to people whose primary language is not English, such as: (1) qualified interpreters and (2) written information in other languages.

If you need these services, contact a consumer advisor at the number on the back of your Member ID card (for TTY help, call 1-800-848-0298 or 711).

If you believe that BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance ("Nondiscrimination Grievance"). For help with preparing and submitting your Nondiscrimination Grievance, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711). They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Compliance Coordinator; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; (423) 591-9208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–368–1019, 800–537–7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

DELTA DENTAL®

	If you use an IN-NETWORK dentist		If you use an OUT-OF-NETWORK dentist	
Calendar-Plan year deductible	Individual $50	Family $150	Individual $50	Family $150
	Deductible applies to all services excluding preventive and diagnostic x-rays.			
Calendar-Plan year annual maximum	$1,500		$1,500	
Preventive services • Routine oral examinations (2 per year) • Bitewing x-rays • Routine cleanings (2 per year)	100% no deductible		100% no deductible	
Basic services • Basic Restorative (Fillings)	80% after deductible		80% after deductible	
Major services • Major Restorative (Crowns) • Periodontics (Gum Disease) • Endodontics (Root Canals) • Prosthodontics (Dentures)	50% after deductible		50% after deductible	
Orthodontia services	Child orthodontia $1,000 lifetime orthodontia maximum.			

DELTA DENTAL

VSP Vision Care

Delta Dental of Tennessee
DeltaVision® Plan 130

Delta Dental has partnered with VSP to provide DeltaVision®. Now you can enjoy the benefits of comprehensive vision care. DeltaVision® offers the same quality coverage, exceptional service, and unparalleled networks you've come to expect from Delta Dental, making it an easy addition to your healthcare network.

DeltaVision 130 Benefits

WellVision Exam		**$10 Copay**
Exams *Once every 12 months*	Comprehensive eye exam to ensure overall visual wellness	
Prescription Glasses		**$25 Copay**
Frames *Once every 24 months*	• $130 allowance for wide selection of frames • 20% savings on amount over allowance • $70 Costco frame allowance	Included in Prescription Glasses Copay
Lenses *Once every 12 months*	• Single vision, lined bifocal and lined trifocal lenses	Included in Prescription Glasses Copay
Covered Lens Enhancements	• Polycarbonate lenses for children • Standard Progressive Lenses	$0
Optional Lens Enhancements *Average savings of 20-25% on other lens enhancements*	• Premium Progressive Lenses • Custom Progressive Lenses • Tints/Photochromic Adaptive Lenses • Scratch Resistant Coating	**Copay Ranges** $95 - $105 $150 - $175 $15 - $17 $17
Contact Lenses - Instead of Glasses		
Contacts *Once every 12 months*	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	up to $60
Extra Savings		
Featured Frames	$150 allowance on featured frame brands. Check vsp.com for current offers.	
Glasses and Sunglasses	20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam	
Retinal Screening	No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam	
Value Added Programs		
Included	Primary Eyecare, Eye Health Management (including Diabetic Exam Reminder Letters)	

Your coverage with Out-of-Network Providers

- Exam - up to $45
- Frame - up to $70
- Single Vision Lenses - up to $30
- Lined Bifocal Lenses - up to $50
- Lined Trifocal Lenses - up to $65
- Lenticular Lenses - up to $100
- Progressive Lenses - up to $50
- Contacts - up to $105
- Necessary Contact Lenses - up to $210

To learn more about DeltaVision® plans visit
DeltaDentalTN.com/DeltaVision

Life Insurance Overview

LIFE INSURANCE

FIXED PREMIUM LIFE INSURANCE

This is a $15,000 Life Policy combined with $15,000 AD&D. It is available for the life of the employee only. The cost of the policy is fixed, not age based. Coverage is guaranteed with no pre-qualification required.

VOLUNTARY LIFE INSURANCE ***FOR NEW HIRES ONLY***

This is a $50,000 or $100,000 policy on the life of the employee. An employee's spouse may also be covered for $25,000 and children ages 6 months to 19 years old (25 if a full-time student) may be covered for $10,000. In order to enroll spouse or children you must have employee coverage.

Coverage is guaranteed and the cost is based on the employee's age. No pre-qualification is required.

DISABILITY INSURANCE ***FOR NEW HIRES ONLY***

Disability Insurance Overview

COVERAGE
Disability income protection insurance provides a benefit for disability resulting from a covered injury or sickness. Benefits begin at the end of the elimination period and continue while you are disabled up to the maximum benefit duration.

ELIGIBILITY
Each Active, Full-Time employee working 30 or more hours per week.

BENEFIT AMOUNT
60% of covered earnings to a maximum benefit of $1,500 per week. After 180 days the maximum benefit increases to $10,000 per month.

ELIMINATION PERIOD
30 consecutive days of total disability.

MAXIMUM BENEFIT DURATION
CONTRIBUTION REQUIREMENTS

The later of your SSNRA* or the Maximum Benefit Period listed below.

Age When Disability Begins Maximum Benefit Period
Age 62 or under...Your 65th birthday or the date the 42nd

Monthly Benefit is payable, if later.

Age 63 The date the 36th Monthly Benefit is payable.
Age 64 The date the 30th Monthly Benefit is payable.
Age 65 The date the 24th Monthly Benefit is payable.
Age 66 The date the 21st Monthly Benefit is payable.
Age 67 The date the 18th Monthly Benefit is payable.
Age 68 The date the 15th Monthly Benefit is payable.
Age 69 or older The date the 12th Monthly Benefit is payable.

FEATURES
Increases in other income Benefits
Conversion Privilege for Disability Insurance Benefits
Mental/Nervous Illness Limitation -24 month out-patient
Offsets (such as, but not limited to, Social Security, Workers Compensation, State Disability Plans)
Pre-Existing Condition Limitation
Rehabilitation provision
Substance Abuse Limitation -24 months
Survivor Benefit -3 months
Transfer of Coverage provision
Return to Work Incentives

EXCLUSIONS

We will not pay any Disability Benefits for a Disability that results, directly or indirectly, from:

1. Suicide, attempted suicide, or self-inflicted injury while sane or insane.

2. War or any act of war, whether or not declared.

3. Active participation in a riot.

4. Commission of a felony.

5. The revocation, restriction or non-renewal of your license, permit or certification necessary to perform the duties of your occupation unless due solely to Injury or Sickness otherwise covered by the Policy.

In addition, we will not pay Disability Benefits for any period of Disability during which you are incarcerated in a penal or corrections institution.

Delta Foremost 401(k)
Plan Highlights

The Internal Revenue Service (IRS) limits the total amount of pre-tax contributions you may make each calendar year. For 2023, this limit is $22,500.00. However, if you reach age 50 anytime during the calendar year or are over 50, you may make additional pre-tax contributions above and beyond normal plan and legal limits. For 2023, you can make up to $7,500.00 in additional contributions.

Rollover Contributions

You may be able to roll over your existing retirement savings into this plan. Consolidating your retirement savings can help you continue benefiting from tax-deferred growth – despite any disruptions that may occur during your working life. Maintaining one retirement account also makes it easy for you to track your retirement savings. To learn more about making Rollover contributions to this plan, call 1-888-526-6905 and a Retirement Specialist will assist you.

Will the company contribute?

The company contribution(s) that you may receive are listed below:

Employer Match Contributions

Your company matches a portion of the pay you contribute as pre-tax contributions. Your Employer Match contributions are calculated as follows:

Your Compensation	Match %
Up to 1% of Compensation	100%
over 1% up to 2% of Compensation	100%
over 2% up to 3% of Compensation	100%
over 3% up to 4% of Compensation	50%
over 4% up to 5% of Compensation	50%

Your Employer Match contributions may not exceed 4.00% of your pay. These contributions grow tax-deferred.

Your Employer Match contributions will be calculated based on your pay each payroll period.

Medical Insurance Rates Plan 1 $4000 Deductible				
	Emp Only	Spouse	Children	Family
Sales Rep (Per Draw)	$54.27	$273.01	$219.32	$368.87
Office Employee (Weekly)	$25.05	$126.01	$101.22	$170.25

Medical Insurance Rates Plan 2 $2500 Deductible				
	Emp Only	Spouse	Children	Family
Sales Rep (Per Draw)	$107.44	$448.27	$364.61	$612.04
Office Employee (Weekly)	$49.59	$206.90	$168.28	$282.48

Medical Insurance Rates Plan 3 $1500 Deductible				
	Emp Only	Spouse	Children	Family
Sales Rep (Per Draw)	$183.45	$607.89	$503.70	$843.10
Office Employee (Weekly)	$84.67	$280.57	$232.48	$389.13

Delta Dental Insurance Rates				
Sales Rep (Per Draw)	$13.00	$25.33	$27.84	$46.60
Office Employee (Weekly)	$6.00	$11.69	$12.85	$21.51

Vision Insurance Rates				
Sales Rep (Per Draw)	$2.30	$4.60	$4.35	$6.80
Office Employee (Weekly)	$1.05	$2.10	$2.00	$3.15

Fixed Life $15,000 Death Benefit	
Sales Rep (Per Draw)	$2.18
Office Employee (Weekly)	$1.00

Disability Insurance	
Sales Rep (Per Draw)	0.229% of Monthly earnings. Maximum benefit 60% of earnings
Office Employee (Weekly)	0.105% of Monthly earnings. Maximum benefit 60% of earnings

Voluntary Life & AD&D Insurance
Employee / Spouse / Child

	Weekly Rates			Bi Monthly Rate (Draw)		
Coverage	$25,000	$50,000	$100,000	$25,000	$50,000	$100,000
Age	Spouse	Employee	Employee	Spouse	Employee	Employee
to age 34	0.78	1.56	3.12	1.69	3.38	6.76
35 to 39	0.92	1.85	3.69	1.99	4.01	7.99
40 to 44	1.27	2.54	5.08	2.75	5.50	11.01
45 to 49	1.79	3.58	7.15	3.88	7.76	15.49
50 to 54	2.71	5.42	10.85	5.87	11.74	23.51
55 to 59	4.27	8.54	17.08	9.25	18.50	37.01
60 to 64	6.46	12.92	25.85	14.00	27.99	56.01
65 to 69	10.85	21.69	43.38	23.51	46.99	93.99
70 to 74	21.87	43.73	87.46	47.38	94.75	189.50
75 and over	44.02	88.04	176.08	95.38	190.75	381.50
Child/ren	0.53			1.15		
Coverage $10,000						
Must have Employee Coverage to have Spouse or Children Coverage						