



Schedule of Benefits...

Specially Designed for The Righter Company

	In-Network	Out-of-Network
Calendar Year Deductible <i>Amount Employee pays before coshare percentages</i>	Single: \$345 Family: \$690	Single: \$690 Family: \$1,380
Coshare Percentage <i>Coshare max doubles per family</i>	20% of 1st \$5,750 THEN 0% FOR BALANCE OF YEAR	20% of 1st \$11,500 THEN 0% FOR BALANCE OF YEAR
Hospital Charges – Inpatient – Outpatient	20% Plan Coshare	20% of Target Prices
Emergency Room Charge <i>Copay is waived if immediately admitted to the hospital</i>	20% Plan Coshare AFTER A \$100 COPAY	20% of Target Prices AFTER A \$100 COPAY
Urgent Care Facility Charge	20% Plan Coshare AFTER A \$40 COPAY	20% of Target Prices AFTER A \$40 COPAY
Sickness/Injury – Physician Charges – Office Visit	20% Plan Coshare \$20 Per Visit	20% of Target Prices 20% of Target Prices
WellCare – Physician Charges – Office Visit	0% Plan Coshare Deductible Waived	0% Plan Coshare Deductible Waived
Other Covered Expenses <i>Coshare Example: Supplies, lab & X-ray, Durable Medical Equipment, Injections, etc</i>	20% Plan Coshare	20% of Target Prices
Retail Prescription Drug – 30 Day Supply	Generic: \$5 Preferred: \$15 Non-Preferred: \$25	60% Plan Coshare All Deductibles Apply
Mail-Order Prescription Drug – 90 Day Supply <i>(Network provider for prescription services is Caremark)</i>	Generic: \$10 Preferred: \$30 Non-Preferred: \$50	N/A
Care Advocacy Pathway (CAP) <i>Care Advocacy Pathway is often referred to as Chronic Care or Disease Management</i>	0% Plan Coshare DEDUCTIBLE WAIVED	0% Plan Coshare DEDUCTIBLE WAIVED

*** This is a summary in outline form of the Benefits. Eligible persons who choose to participate should review the SUMMARY PLAN DESCRIPTION and PLAN DOCUMENT (Benefit Booklet) for information about; participation, benefits, limitations, and exclusions. This is not a contract, policy or guarantee of coverage.***



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Other Coverage Notes:

- Second Surgical Opinion requested by BAC, Hospice, Centers of Excellence, and Pre-Admission Testing recommended by BAC, and Optional Benefits are paid by the Plan at 100% (0% member out of pocket) of covered expenses.
- Deductible waived for Maternity Care (if treatment begins within 1st trimester).
- Deductible waived for Out-Patient Surgical visits.
- Network provider for prescription services is Caremark.
- If brand name drugs are purchased when a generic is available the member will be responsible for the difference in cost between the brand and the generic plus the generic deductible.
- Lifetime Maximum for treatment of Temporomandibular Joint Dysfunction Syndrome (TMJ) is \$1,000.
- Chiropractic Services limited to a maximum benefit of 12 visits per year.
- Annual Maximum for all Benefits paid under this plan is \$2,000,000.
- Lifetime Maximum for all Benefits paid under this plan is unlimited.

Target Prices – are used as the maximum allowable payment for out-of-network (non-participating) providers. The Target Price fee schedule applies to provider procedure codes (called CPT-4's or DRG's) and will cover most charges made by a Provider. The Target fee schedule is 115% of the Medicare reimbursement rate, which means that reimbursement is set at 15% more under this Plan than is paid for providing the same service to a Medicare patient. Any provider charge in excess of the Target Price will not be a covered expense under the terms of this Plan and will be the responsibility of the Covered Person.

If you choose to see an out-of-network Provider, you should ask prior to treatment if he or she will accept Target Price (115% of the Medicare reimbursement) as payment-in-full. If the Provider agrees you will not be responsible for any excess charge. Therefore, it is important that you obtain written verification. If not, you will be responsible for paying the balance of the charges.



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Dental Expense Benefit:

Calendar year Deductible: \$50/Person
Annual Maximum: \$1500/Year

Coshare:	Type 1	Preventive Care (No Deductible).....	0%
	Type 2	Basic Restorative (after Deductible).....	20%
	Type 3	Major Restorative (after Deductible).....	50%
	Type 4	Orthodontia (after Deductible).....	50%

• **PREVENTIVE CARE SERVICES INCLUDE:**

Oral Exams, Cleaning of Teeth, Bite-Wing X-rays, Prophylaxis & Fluoride Treatments

• **BASIC RESTORATIVE SERVICES INCLUDE:**

Extractions, Fillings, Root Canals & Endodontic Treatments

• **MAJOR RESTORATIVE SERVICES INCLUDE:**

Crowns, Inlays, Onlays, Dentures & Bridgework

• **ORTHODONTIA LIFETIME MAXIMUM: \$1,000.00**

Applies to covered dependents under age 19

Vision Care Benefits:

Maximum Reimbursement Schedule:

- Complete Eye Exam (per covered individual) \$50..... One every 12 Months
- Frames & Lenses (per covered individual) \$200..... One every 12 Months

Lens tinting, initialing and sunglasses are not eligible expenses. Benefits are available for either contact lenses or glasses (one or the other, but not both) once every 12 Months.