Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Racine Unified School District Retiree Medical Savings Account:

Coverage Period: 01/01/2020 – 12/31/2020

Coverage for: Employee and family | Plan Type: Expense Reimbursement

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage [http://www.rusd.org/1-262-619-4631](http://www.rusd.org/1-262-619-4631). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [https://www.healthcare.gov/sbc-glossary/](https://www.healthcare.gov/sbc-glossary/) or call 1-262-619-4631 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes.</td>
<td>This plan has no deductible.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>Not Applicable.</td>
<td>This plan does not have an out-of-pocket limit on your expenses.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Not Applicable.</td>
<td>This plan does not have an out-of-pocket limit on your expenses.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Not Applicable.</td>
<td>This plan does not use a provider network. You can receive covered services from any provider.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Released on April 6, 2016
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
</table>
| If you visit a healthcare provider's office or clinic | Primary care visit to treat an injury or illness  
Specialist visit  
Preventive care/screening/immunization | | |
| If you have a test                          | Diagnostic test (x-ray, blood work)  
Imaging (CT/PET scans, MRIs) | | |
| If you need drugs to treat your illness or condition  
More information about prescription drug coverage is available at www.[insert].com | Generic drugs (Tier 1)  
Preferred brand drugs (Tier 2)  
Non-preferred brand drugs (Tier 3)  
Specialty drugs (Tier 4) | No Charge | Coverage is (a) limited to expenses incurred after termination, and (b) limited to individual's account balance. |
| If you have outpatient surgery              | Facility fee (e.g., ambulatory surgery center)  
Physician/surgeon fees | | |
| If you need immediate medical attention     | Emergency room care  
Emergency medical transportation  
Urgent care | | |
| If you have a hospital stay                 | Facility fee (e.g., hospital room)  
Physician/surgeon fees | | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services  
Inpatient services | | |
| If you are pregnant                         | Office visits  
Childbirth/delivery professional services  
Childbirth/delivery facility services | | |
<table>
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</thead>
<tbody>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No Charge</td>
<td>Coverage is (a) limited to expenses incurred after termination, and (b) limited to individual’s account balance.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td></td>
<td></td>
</tr>
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</table>

**Excluded Services & Other Covered Services:**

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery

**Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)**

- Acupuncture
- Bariatric Surgery
- Chiropractic care
- Dental care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight Loss Programs

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-262-619-4631.

**Does this plan provide Minimum Essential Coverage?** Yes.

If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.
Does this plan meet Minimum Value Standards?  No.
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
[7] [Spanish (Español): Para obtener asistencia en Español, llame al 1-262-619-4631.]
[7] [Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-262-619-4631.]
[7] [Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-262-619-4631.]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments, and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan’s overall deductible: $0
- Specialist copayment: $0
- Hospital (facility) coinsurance: 0%
- Other coinsurance: 0%

This EXAMPLE event includes services like:
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

| Total Example Cost | $12,800 |

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
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<tr>
<td>Deductibles</td>
<td>$0</td>
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What isn’t covered:

- Limits or exclusions

The total Peg would pay is **

### Managing Joe’s type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan’s overall deductible: $0
- Specialist copayment: $0
- Hospital (facility) coinsurance: 0%
- Other coinsurance: 0%

This EXAMPLE event includes services like:
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

| Total Example Cost | $7,400 |

In this example, Joe would pay:

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What isn’t covered:

- Limits or exclusions

The total Joe would pay is **

### Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

- The plan’s overall deductible: $0
- Specialist copayment: $0
- Hospital (facility) coinsurance: 0%
- Other coinsurance: 0%

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

| Total Example Cost | $1,900 |

In this example, Mia would pay:

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What isn’t covered:

- Limits or exclusions

The total Mia would pay is **

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments, and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

*Amount in excess of individual’s account balance.

**Amount in excess of his/her account balance under this plan if expense is not covered by another plan (i.e. the group medical coverage).

The plan would be responsible for the other costs of these EXAMPLE covered services if not covered by another plan.