Racine Unified School District Prescription Drug Plan Coverage Period: 7/1/2017 – 6/30/2018

Summary of Benefits and Coverage: What This Plan Covers & What it Costs **Coverage for: Employee + Family** **Plan Type: PS1**

This is only a summary. If you want more detail about your coverage and costs, please contact Express Scripts at 800-711-5672 or www.express-scripts.com

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$1500** Individual / **$3000** Family Non-Network: **$2500** Individual */ **$5000** Family Doesn't apply to services listed below as "No Charge." Per calendar year. *Doesn't apply if policy covers 2+ people.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Your deductible starts over every January 1st. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No. There are no other deductibles.	None
Is there an out-of-pocket limit on my expenses?	No	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services
What is not included in the out-of-pocket limit?	This plan has no out of pocket limit.	NA because there is no out of pocket limit on your expenses for this plan.
Is there an overall annual limit on what the plan pays?	No	None
Does this plan use a network of providers?	Yes, this plan uses network pharmacies. For a list of network providers, see **www.express-scripts.com** or call 800-818-0093 for a list of network pharmacies.	If you use a network pharmacy, this plan will pay some or all of the costs of covered services
Do I need a referral to see a specialist?	NA	None
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See your SPD for additional information about excluded services

- Co-payments (copays) are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Co-insurance (co-ins) is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your co-insurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If a non-network provider charges more than the allowed amount, you may have to pay the difference. For example, if a non-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use network providers by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Non-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not Covered	Not Covered	None
	Specialist visit	Not Covered	Not Covered	None
	Other practioner's office visit	Not Covered	Not Covered	None
	Preventive care/screening/immunization	Not Covered	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	Not Covered	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Not Covered	Not Covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at **www.express-scripts.com**	Tier 1 – Your Lowest-Cost Option	Retail: $0 Mail-Order: $0	Not Covered	Copays apply after deductible is met. Covers up to 30 day supply for retail prescriptions and up to 90 day supply for mail order prescriptions.
	Tier 2 – Your Midrange-Cost Option	Retail: $15 Mail-Order: $30	Retail: $15 Mail-Order: $30	Copays apply after deductible is met. Covers up to 30 day supply for retail prescriptions and up to 90 day supply for mail order prescriptions.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Non-Network Provider	
	Tier 3 – Your Highest-Cost Option	Retail: $25 Mail-Order: $50	Retail: $25 Mail-Order: $50	Copays apply after deductible is met. Covers up to 30 day supply for retail prescriptions and up to 90 day supply for mail order prescriptions.
	Tier 4 – Additional High-Cost Option (Specialty)	Retail: $15 Mail-Order: $30	Retail: $15 Mail-Order: $30	Copays apply after deductible is met. Covers up to 30 day supply for retail prescriptions and up to 90 day supply for mail order prescriptions.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	None
	Physician/surgeon fee	Not Covered	Not Covered	None
If you need immediate medical attention	Emergency room services	Not Covered	Not Covered	None
	Emergency medical transportation	Not Covered	Not Covered	None
	Urgent Care	Not Covered	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered	Not Covered	None
	Physician / surgeon fee	Not Covered	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not Covered	Not Covered	None
	Mental/Behavioral health inpatient services	Not Covered	Not Covered	None
	Substance use disorder outpatient services	Not Covered	Not Covered	None
	Substance use disorder inpatient services	Not Covered	Not Covered	None
If you become pregnant	Prenatal and postnatal care	Not Covered	Not Covered	None
	Delivery and all inpatient services	Not Covered	Not Covered	None
If you have a recovery or other special health needs	Home health care	Not Covered	Not Covered	None
	Rehabilitation services	Not Covered	Not Covered	None
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	Not Covered	Not Covered	None
	Durable medical equipment	Not Covered	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Non-Network Provider	
	Hospice service	Not Covered	Not Covered	None
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	None
	Glasses	Not Covered	Not Covered	None
	Dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Drugs or medications that can be lawfully obtained without a prescription, even if your physician prescribes them • Drugs or medications that are deemed to be ineffective or marginally effective • A drug or medication that has not been proven to be more effective than a less expensive therapeutically equivalent drug. • Any drug or medication labeled, "Caution-limited by federal law to investigational use." This exclusion does not apply to drugs for the treatment of HIV infection that are required by law to be covered.	• Any drug that has not been approved by the FDA for the purpose for which it is being used. • Drugs or medications for the treatment of alopecia or hair loss. • Drugs or medications prescribed primarily to improve appearance. This includes all dosage forms of tretinoin for individuals who are 26 years or older, except for the treatment of acne. • Drugs or medications prescribed for or in connection with weight loss or weight control.	• Drugs or medications prescribed for or in connection with infertility or conception. • Early refills, refills in excess of the number of refills specified by the physician, or any refill dispensed after one year from the date of the physician's original order, unless authorized. • Drugs or medications covered under any Workers' Compensation law or similar laws or any municipal, State or Federal program, even if the patient chooses not to claim such benefits. • Drugs or medications provided in connection with any medical services not covered under the medical plan.
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
Coverage is available for these drugs and medications when they are determined to be medically necessary, medically appropriate, and cost-effective: • Those required to carry the legend, "Federal law prohibits dispensing without a prescription." • Those that may be dispensed only upon a physician's written prescription as required by State law	• Those for the treatment of HIV infection. • Insulin and other prescription drugs and medications prescribed for the treatment of diabetes.	Smoking deterrent drugs or medications or smoking cessation aids.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit http://www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit http://www.cciio.cms.gov.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact your human resource department or the Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http:///ciio.cms.gov/prgrams/consumer/capgrants/index.html.

Para obtener asistencia en español, llame al número de teléfono en su tarjeta de identificación.
若需要中文协助，请拨打您会员卡上的电话号码
Dine k'ehji shich'i' hadoodzih ninizingo, bee neehozin biniiye nanitinigii number bikaa'igii bich'i' hodiilnih
Para sa tulong sa Tagalog, tawagan ang numero sa iyong

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next page*----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- ☐ **Amount owed to providers:** $2,000
- ☐ **Plan Pays** $470
- ☐ **Patient Pays** $1,530

Sample care costs:

Hospital charges (mother)	$0
Routine obstetric care	$0
Hospital charges (baby)	$0
Anesthesia	$0
Laboratory tests	$0
Prescriptions	$2,000
Radiology	$0
Vaccines, other preventive	$0
Total	**$2,000**

Patient pays:

Deductibles	$1500
Co-pays	$30
Co-insurance	$0
Limits or exclusions	$0
Total	**$1,530**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- ☐ **Amount owed to providers:** $3,500
- ☐ **Plan Pays** $600
- ☐ **Patient Pays** $2,900

Sample care costs:

Prescriptions	$3,500
Medical Equipment and Supplies	$0
Office Visits and Procedures	$0
Education	$0
Laboratory tests	$0
Vaccines, other preventive	$0
Total	**$3,500**

Patient pays:

Deductibles	$1,500
Co-pays	$1,400
Co-insurance	$0
Limits or exclusions	$
Total	**$2,900**

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.
- If other than individual coverage, the Patient Pays amount may be more.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No**. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides

Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.