Rhode Island Public Employees Health Services Fund- Local Union1033:
Express Scripts Rx Plan - 1 855-525-8001 or visit express-scripts.com

Coverage Period:01/01/2020-6/30/2021

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Group | **Plan Type:** Prescription

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document. Please refer to your medical plan's Summary of Benefits and Coverage for more information.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$	**Please refer to your medical plan's Summary of Benefits and Coverage.Your Rx Plan has a $0. deductable**
Are there other deductibles for specific services?	$	
Is there an out–of–pocket limit on my expenses?	$ 1,300/individual $ 2,600/family	A separate Rx maximum out-of-pocket amount applies per plan year (7/1 to 6/30) for prescription benefits. Once met, a $0 copay will apply for the remainder of the plan year.
What is not included in the out–of–pocket limit?	$ Copay differentials	Brand-generic copay differentials do not apply to the out-of-pocket amount if a participant selects a brand name drug when a generic was available and medically appropriate.
Is there an overall annual limit on what the plan pays?	Your Union Rx Plan does not have an annual limit or maximum benefit.	**Please refer to your medical plan's Summary of Benefits and Coverage.**
Does this plan use a network of providers?	Yes, see our National Network at www.express-scripts.com	
Do I need a referral to see a specialist?		
Are there medications this plan doesn't cover?	Yes, Your Union Rx Plan covers certain Oral medications, Insulin and EpiPens	

Questions: Call **1 855-525-8001 or visit express-scripts.com**
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-800-687-0707 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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 an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-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 participating **providers** by charging you lower **deductibles, copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**Please refer to your medical plan's Summary of Benefits and Coverage.**		
	Specialist visit			
	Other practitioner office visit			
	Preventive care/screening/immunization			
If you have a test	Diagnostic test (x-ray, blood work)			
	Imaging (CT/PET scans, MRIs)			

Common Medical Event	Services You May Need	Retail Pharmacy (30 day supply)	Mail Order or CVS Smart 90 (90 day supply)	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at our Website exspress-scripts.com or by calling 1-855-525-8001.	Generic drugs	$5 co-pay	$10 co-pay	-Member will pay copay plus difference is cost when a brand is dispensed and generics are available. -Certain drugs may have Quantity Limits, Prior Authorization, or Step Therapy requirements applied. Call 1 855 525 8001 with questions.
	Preferred drugs	$15 co-pay	$30 co-pay	
	Non-Preferred brand drugs	$30 co-pay	$60 co-pay	
	Specialty drugs (Oral only)	Same as above (30 day supply)	N/A – only 30 day supply allowed.	-Oral specialty medications are, after the initial fill, restricted to be refilled at Accredo Specialty Pharmacy, Call 1 800 803 2523. For other specialty injectable drugs, see Medical plan.
	Preventive drugs (including aspirin, folic acid, iron, fluoride supplements, as designated by law)	$0 co-pay	$0 co-pay	-Certain preventive drugs are covered *for specific ages* at $0 copay with a written prescription.
	Contraceptives (Oral, emergency, rings, patches, OTC-with prescription)	Generic - $0 co-pay Brands with no generic - $0 copay Brands with generic available – $0*	Generic - $0 co-pay Brands with no generic - $0 copay Brands with generic available – $0*	-Brand oral contraceptives require use of 2 generics in previous 180 days. -Devices, implants, and injectables are excluded. See Medical plan. -*Brand contraceptives with generic available require prior authorization.
	Proton Pump Inhibitors (PPI) and Non-Sedating Antihistamines (NSA) drugs	$5 co-pay	$10 co-pay	Brand, Generic & over-the-counter (OTC) PPI & NSA drugs are excluded. In certain situations, the Rx may be covered with a prior authorization.

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**Please refer to your medical plan's Summary of Benefits and Coverage.**
	Physician/surgeon fees	
If you need immediate medical attention	Emergency room services	
	Emergency medical transportation	
	Urgent care	
If you have a hospital stay	Facility fee (e.g., hospital room)	
	Physician/surgeon fee	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	
	Mental/Behavioral health inpatient services	
	Substance use disorder outpatient services	
	Substance use disorder inpatient services	
If you are pregnant	Prenatal and postnatal care	
	Delivery and all inpatient services	
If you need help recovering or have other special health needs	Home health care	
	Rehabilitation services	
	Habilitation services	
	Skilled nursing care	
	Durable medical equipment	
	Hospice service	
If your child needs dental or eye care	Eye exam	
	Glasses	
	Dental check-up	

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.)

- Acne Antibiotics Oral long acting products (i.e. Solodyn, Doryx, Oracea)
- Weight loss Rx, covered only with a PA.
- Allergy serum/extracts
- Amrix Anabolic steroids
- Antifungal Topical brand products (i.e. Naftin & Metanx)
- Anti-sera/immune globulins
- Anti-wrinkle agents (i.e. Renova)
- Arestin
- Blood, blood factors, plasma or biological sera
- Cambia
- Colony Stimulating Factors
- Contraceptive devices, implants, injectables, brands with generic available.
- Cosmetic hair removal products (i.e. Vaniqa)
- Depigmenting agents (i.e. Hydroxyquinone)
- Dental products OTC-(i.e. topical fluoride rinses)
- Diabetic supplies – (i.e. insulin pens/syringes/needles, test strips, lancets)
- Dolgic Plus and Orbivan
- Drugs indicated for cosmetic uses
- Drugs for Erectile Dysfunction maybe covered with a prior authorization.
- Fortamet
- Glucometers
- Growth hormones
- Hair growth stimulants
- Homeopathic/natural legend products
- Immunizations/Vaccines/Toxoids
- Injectable medications except for insulin, and EpiPen kits.
- Me Too Exclusion List *(subject to change)

including, ABSORICA, ALLZITAL, AMRIX CAP, APAP/CAFFEIN TAB DIHYDROC, APLENZIN TAB, APTENSIO XR, ARESTIN MIS 1MG, AUVI-Q INJ, AZASAN TAB, BUPAP, CLINDAGEL GEL 1%, CONZIP CAP, DAXIBA CAP 333MG, DUEXIS TAB, DURLAZA 162.5 MG TAB, ENTTY EMU SPRAY, EVZIO INJ, FENORTHO CAP, FERIVA 21/7, FEXMID TAB (BRAND), FIBRIK CAP, FLOLIPID SUSP, FORTAMET (BRAND), GLUMETZA, HYDROSORTISONE OINTMENT ABSORBAS, INDERAL LA (BRAND), INDOCIN 50MG SUPP, INPEN 100EL or 100NN, IRENKA, KAMDOY EMU, KLOFENSAID SOL II, LIVIXIL PAK KIT 2.5-2.5%, LODINE CAP, LORZONE TAB, LYRICA CR, METOCLOPRAMIDE ODT, MEXPAROX HC CREAM 2.5%, MILLIPRED 5 MG TAB, MOTOFEN 1-0.025, NORITATE CREAM, ONMEL 200 mg, ONZETRA NASAL, PENNSAID 2%, PEPCID TABLETS, PEXEVA TAB, PHLAG SPRAY, PRESTALIA, PRIMLEV, RAYOS TAB, RELADOR PAK KIT 2.5-2.5%, RELADOR PAK KIT PLUS, SALIMEZ CREAM 6%, SPRITAM TAB, SYNERDERM EMU, TIVORBEX CAP, VANATOL, VANOS CREAM 0.1%, VENLAFAXINE ER TABLETS 37.5mg, 75 mg, 150 mg, VIMOVO TAB, VITAMEZ CAP, VIVLODEX CAP, XTAMPZA ER CAP, YOSPRALA TAB, ZECUITY PAD, ZEGERID, ZEMBRACE INJ, ZIPSOR CAP, ZORVOLEX

- Naprelan
- Over the Counter (OTC) drugs are not covered excepting those deemed Preventative under the ACA.
- Non-sedating antihistamines
- Nutritional supplements
- Ophthalmic Antihistamine brand products
- Proton Pump Inhibitors (PPI) unless Brand is necessary with PA.
- Supplies, devices, or appliances,
- Syringes/needles
- Topical Tretinoin brand products (i.e. Retin-A, Retin-A Micro, Tretin-X)
- Topical Antiviral brand products
- Topical Corticosteroid brand products
- Triptans (anti-migraine agents) brand products (i.e. Imitrex, Relpax)
- Triptans brand combination products (i.e. Treximet)
- Vitamins-other than Rx prenatal, folic acid, and vitamin D.

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.)
• Please refer to your medical plan's Summary of Benefits and Coverage.

Your Rights to Continue Coverage:

If you lose coverage under the plan, 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 401-331-1050. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

For Assistance in obtaining a Prior Authorization, call 1 855 525 8001, your treating Physician will be requiued to submit clinical and other medical evidence to support your request.

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 the Clinical Appeals Department plan at 800 753 2851.

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

Coverage Examples

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:**
- **Plan pays**
- **Patient pays**

Sample care costs:

Hospital charges (mother)	N/A
Routine obstetric care	N/A
Hospital charges (baby)	N/A
Anesthesia	N/A
Laboratory tests	N/A
Prescriptions	
Radiology	N/A
Vaccines, other preventive	N/A
Total	

Patient pays:

Deductibles	$0
Copays	
Coinsurance	$0
Limits or exclusions	$0
Total	

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

- **Amount owed to providers:**
- **Plan pays**
- **Patient pays**

Sample care costs:

Prescriptions	
Medical Equipment and Supplies	
Office Visits and Procedures	N/A
Education	N/A
Laboratory tests	N/A
Vaccines, other preventive	N/A
Total	

Patient pays:

Deductibles	$0
Copays	
Coinsurance	$0
Limits or exclusions	$0
Total	

Questions and answers about the 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 by 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.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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.

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