BENEFITS-AT-A-GLANCE – TEACHERS 2020

RACINE UNIFIED SCHOOL DISTRICT

COVERAGE CATEGORY	UHC MEDICAL		COVERAGE CATEGORY	DELTA DENTAL Traditional *Balance billing if not PPO	DELTA DENTAL EPO Must be PPO provider
Monthly Cost • Individual Coverage • Family Coverage • Family + Secondary Spouse Coverage	Monthly Per Pay (20) $ 21.69 $13.01 $ 43.40 $26.04 No Charge		Monthly Cost • Individual Coverage • Family Coverage	Monthly Per Pay (20) $ 2.96 $ 1.78 $ 7.44 $ 4.46	Monthly Per Pay (20) $ 23.06 $ 13.84 $ 93.68 $ 56.21
	In Network	**Out of Network**			
Deductible • Individual • Family	$1,500 $3,000	$2,500 $5,000	Deductible • Individual • Family	$25 $75	None
Coinsurance	Deductible plus 10%	Deductible plus 30%	Coinsurance	Varies based on type of service	None
Out-of-Pocket Maximum • Individual • Family	$2,000 $4,000	$3,000 $6,000	Annual Maximum	$1,000 per person	None
Preventive Care • Mammography	Covered at 100%	Deductible plus 30%	Preventive • Prophylaxis • Fluoride (Age limits) • Sealants	Covered at 100%	Paid in full
Urgent Care	Deductible plus 10%	Deductible plus 30%	Diagnostic • Oral Exam • Cleanings • X-ray • Lab • Space Maintainers	Covered at 100%	Paid in full
Emergency Care	$150 Copay (waived if admitted) plus deductible and coinsurance for emergency services		Basic Restorative • Fillings • Root canal • Denture Repairs • Simple Extractions	Covered at 80%	Paid in full
Lab and Radiology	Deductible plus 10%	Deductible plus 30%	Major Restorative • Implants • Repairs to bridges • Repair to dentures	Covered at 80%	Paid in full
Diagnostic • MRI • CT Scan • PET Scan	Deductible plus 10%	Deductible plus 30%	Oral Surgery	Covered at 80%	Paid in full
Hospital • Inpatient • Outpatient • Maternity	Deductible plus 10%	Deductible plus 30%	Periodontics	Covered at 80%	Paid in full
Rehabilitation • Inpatient • Outpatient • Skilled Nursing	Deductible plus 10%	Deductible plus 30%	Endodontics	Covered at 80%	Paid in full
Mental Health • Inpatient • Outpatient • Substance Abuse	Deductible plus 10%	Deductible plus 30%	Major Services • Dentures • Prosthetics • Inlays/onlays • Bridges	Covered at 50%	Paid in full
Special Coverage • Chiropractic • Durable Medical • Home Health Care	Deductible plus 10%	Deductible plus 30%	Orthodontic Services	50% coinsurance Up to $1,500 lifetime maximum per person (age 19 limit)	$450 copay per person (Adult and children coverage)
Prescription Drugs – Retail (30-day supply) • Generic • Brand (Formulary) • Brand (Non-formulary)	Deductible plus $ 0 Copay Deductible plus $15 Copay Deductible plus $25 Copay *Once Deductible is met				
Prescription Drugs – Mail Order (90-day supply) • Generic • Brand (Formulary) • Brand (Non-formulary)	Deductible plus $ 0 Copay Deductible plus $30 Copay Deductible plus $50 Copay *Once Deductible is met				

Vision Plan Monthly Cost • Employee Only • Employee + Spouse • Employee + Child(ren) • Family	Monthly / Per Pay (20) $ 4.57 / $2.74 $ 9.15 / $5.49 $13.15 / $7.89 $18.74 / $11.24	
Examination (once every 12 months)	$10 Copay	
Standard Glass or Plastic Lenses (once every 12 months) • Single/Bifocal • Trifocal/Lenticular • Polycarbonate • Standard Scratch Coating	**In Lieu of Contact Lenses** $25 Copay $25 Copay Covered at 100% (up to age 19) Covered at 100% (up to age 19)	
Frames (once every 12 months)	**In Lieu of Contact Lenses** $150 retail allowance 20% off balance owed	
Contact Lenses (once every 12 months) • Elective Contact Lenses • Fit and Follow-up • Medically Necessary	**In Lieu of Lenses and Frames** $130 retail allowance 15% off balance owed for Conventional 10% off balance owed for Disposable $20 Copay for Standard Daily Wear $30 Copay for Standard Extended Wear $50 Copay for Specialty Wear Covered at 100%	
Employee Assistance Program (EAP)	• District paid • Comprehensive assessments • Crisis counseling • Financial guidance and legal advice	
Health Reimbursement Account (HRA)	• $1,000 District contribution for enrollment in medical plan family coverage • $ 500 District contribution for enrollment in medical plan individual coverage • Additional District contribution for participation in Wellness Program • Funds can be used for health-related expenses	
Flexible Spending Accounts (FSA) • Health Care • Dependent Care	• Contribute up to $2,750 on pre-tax basis for health care each calendar year • Contribute up to $5,000 on a pre-tax basis for dependent care each calendar year • Re-enrollment required each calendar year • Use it or lose it per calendar year per IRS regulations	
Life Insurance • Employee • Dependent	**Employee** • Basic 1 times annual salary • Supplemental 1 times annual salary • Additional 1, 2 or 3 times annual salary • Premiums based on age • See Rate Sheet for calculation	**Dependent** • Spouse at $10,000 or $20,000 • Children at $5,000 or $10,000
Short-term Disability	• Employee paid • No elimination period for accident • 3 calendar day elimination period for illness • 60-day benefit period • Weekly benefit not to exceed 66% of weekly average wage • * Evidence of Insurability required	Weekly Rate / Per Pay (20) $147.00 / $6.05 $175.00 / $7.06 $224.00 / $9.06 $273.00 / $11.09 $301.00 / $12.10 $357.00* / $14.45 $420.00* / $16.80 $462.00* / $18.48 $504.00* / $20.16
Long-term Disability	• District paid • 60 calendar day elimination period • Begins on 61st day of disability • 70% of annual salary • Automatic enrollment • Pre-existing condition limits apply	
RETIREMENT PROGRAMS		
Wisconsin Retirement System (WRS)	• Employee contribution determined by ETF; 6.75% for 2020 • District contribution determined by ETF; 6.75% for 2020 • Automatic Enrollment with payroll deductions • Vested after 5 creditable years of service indicated on the ETF annual statement	
Tax Sheltered Annuities (403b/457 Plan)	• Employee pre-tax contribution for retirement • Payroll deduction • IRS limits apply • Investment options • NOTE: You must first set up your account under RUSD before submitting payroll authorization form.	