City of La Crosse Schedule of Benefits
Effective 1/1/2022
ATU Local #519

The following is a summary of your benefits. Please review specific plan provisions within the Master Plan/Summary Plan document to ensure you understand the complete benefit(s).

Provision	In Network	Out-of-network
Annual deductible	$275 per Covered Person per year; not to exceed $825 per Family Unit.	$600 per Covered Person per Year with no Family Unit maximum.
	Deductibles for in network and Out-of-network do not cross apply. Any fixed-dollar co-pays are applied to the amount of allowable expense before the annual deductible. The deductible amount is not satisfied or lowered by any fixed-dollar co-pay amounts, any amounts exceeding the fixed-dollar and fixed-visit limits, excluded items, any amounts exceeding UCR when Out of Network or outpatient prescription drug costs.	
Co-insurance after deductible is met (Any Co-pay is additional)	Plan generally pays 100%, following the deductible, EXCEPT as otherwise stated.	Plan generally pays 80% following the deductible, EXCEPT as otherwise stated. No out of pocket maximum.
Maximum Out of Pocket (MOOP)	$8,700 Individual / $17,400 Family Deductible, co-insurance, co-payments & Rx drug co-payments incurred in network are included.	No Out of Pocket Maximum
Usual, Customary, & Reasonable (UCR) fee limit	UCR does not apply to In Network charges.	UCR applies, Except as noted.
Pre-certification	Pre-certification is recommended for inpatient confinement, outpatient surgeries performed in outpatient hospital or surgical center, therapy services for more than five visits per Year, durable medical equipment, home health care, chiropractic care for more than 13 visits per Calendar Year, outpatient mental illness or chemical dependency for more than five visits per Calendar Year, immunizations for respiratory syncytial virus (RSV), dental restorative services, oral surgery, TMJ or other procedures as otherwise specified.	

Covered Benefit	In Network	Out-of-network
Professional Ambulance	Plan pays 100% following the deductible for transportation to nearest local facility that provides the required treatment *(when medically necessary).*	Plan pays 100% of billed charges following the **in-network** deductible for transportation to nearest local facility that provides the required treatment *(when medically necessary).*
Autism	Plan pays 100% following the deductible when medically necessary for the conditions as outlined below.	Plan pays 80% of UCR charges following the deductible when medically necessary for the conditions as outlined below.
	Treatment of Autism, Asperger Syndrome and Pervasive Development Disorder if treatment is recommended by an appropriate provider in accordance with the terms and conditions and limitations of Wis. Stat 632.895(12m). Participants should call their Plan Supervisor customer service for specific treatment limitations and exclusions under the Plan. Pre-certification is recommended. A copy of the State Statute is available from the Plan Administrator.	
Chiropractic	Plan pays 100% following $20 co-pay per daily visit and/or exam and deductible *(Maintenance Services are excluded).*	Plan pays 100% of UCR charges following $25 co-pay per daily visit and/or exam and deductible *(No Medical Necessity standard).* **Limited to 18 out-of-network visits per calendar year.**
Convenience Clinics	Plan pays 100%, no co-pay or deductible applies to visit	Plan pays 80%, no co-pay or deductible applies to visit
Cochlear Implants (Children under age 18 who are profoundly hearing impaired)	Plan pays 100% following deductible. Prior authorization recommended.	Plan pays 80% of UCR charges following the deductible. Prior authorization recommended.
Dental Preventive or Diagnostic Services	No benefits except to the extent the Plan provides coverage for diagnostic services required for allowable types of dental and TMJ services stated below.	

Covered Benefit	In Network	Out-of-network
Dental Restorative Services - Basic (When Functionally Necessary) & Dental or Oral Surgery	Plan pays 100% following $20 co-pay per visit or exam and deductible. Precertification notice recommended.	Plan pays 100% of UCR charges following $25 co-pay per visit or exam and deductible. Should service not be available in network, Plan will pay 100% of UCR charges following $20 co-pay per visit and/or exam following the **in-network** deductible. Precertification notice recommended.
	Restorative services limited to repair or replacement of a natural tooth injured by blunt external force, other than chewing, within six months of such injury. Dental or oral surgery limited to 15 specific types of procedures and surgical TMJ services.	
Dental Restorative Services – Major (When Functionally Necessary)	Plan pays 80% following $20 co-pay per visit or exam and deductible. Precertification notice recommended.	Plan pays 80% of UCR charges following $25 co-pay per visit or exam and deductible. Should service not be available in network, Plan will pay 80% of UCR charges following $20 co-pay per visit or exam and the **in-network** deductible. Precertification notice recommended.
	Limited to simple non-cutting extraction of a natural erupted tooth and the initial replacement with an artificial tooth, when necessary (including initial partial dentures or bridgework).	
Diagnostic x-ray and lab or Non-PPACA Preventive x-ray and lab (Non-Hospital)	Plan pays 100% following the deductible.	Plan pays 80% of UCR charges following the deductible. Lab services for emergency care are covered at 100% of billed charges following deductible for services originating from hospital outpatient emergency department until such discharge.
Durable Medical Equipment	Plan pays 100% following the deductible. Precertification notice recommended for rental or purchase.	Plan pays 80% of UCR charges following the deductible. Precertification notice recommended for rental or purchase.
Emergency room (includes facility and physician charges)	Plan pays 100% following $75 co-pay and deductible. Copay is waived when admitted as an Inpatient within 24 hours.	Plan pays 100% of billed charges following $75 co-pay and **in-network** deductible.. Copay is waived when admitted as an Inpatient within 24 hours.
Hearing Aids (Children under age 18)	Plan pays 100% following the deductible when medically necessary according to the below time frames and age guidelines.	Plan pays 80% of UCR charges following the deductible when medically necessary according to the below time frames and age guidelines.
	Charges for external hearing aids for children under age eighteen (18) are covered to a maximum of one hearing aid per child, per ear every three (3) years.	
Home Health Care	Plan pays 100% following the deductible. Precertification notice recommended.	Plan pays 80% of UCR charges following the deductible. Precertification notice recommended.
	Maximum benefit of 40 visits per Covered Person per Calendar Year combined for in network and out-of-network charges.	

Covered Benefit	In Network	Out-of-network
Hospice Care	Plan pays 100% following the deductible. Precertification notice recommended.	Plan pays 80% of UCR charges following the deductible. Precertification notice recommended.
	Maximum benefit of 180 daily visits per person per lifetime combined for in network and out-of-network charges.	
Hospital-Inpatient (Room & Board)	Plan pays 100% following the deductible. Precertification notice recommended.	Plan pays 80% of UCR charges following the deductible. Services for emergency care are covered at 100% of billed charges after the **in-network** deductible for facility services continuous from the hospital outpatient emergency department through any immediately succeeding inpatient stay. Precertification notice recommended.
Hospital Outpatient (including diagnostic x-ray, lab tests and screenings)	Plan pays 100% following the deductible. Precertification notice recommended.	Plan pays 80% of UCR charges following the deductible. Services for emergency care are covered at 100% of billed charges after the **in-network** deductible for services originating from Hospital Outpatient emergency department until discharge. Precertification notice recommended.
Mental health and substance abuse - Inpatient	Plan pays 100% following the deductible. If a physician charges a separate fee for the inpatient office visit, Plan pays 100% following $20 co-pay per visit or exam and deductible. *(Maintenance services excluded)* Precertification notice recommended.	Plan pays 80% of UCR charges following the deductible. If a physician charges a separate fee for the inpatient office visit, Plan pays 80% of UCR charges following $25 co-pay per visit or exam and deductible. Services for emergency care are covered at 100% of billed charges after the **in-network** deductible for facility services continuous from the hospital outpatient emergency department through any immediately succeeding inpatient stay. *(Maintenance services excluded)* Precertification notice recommended.
Mental health and substance abuse - Outpatient (including urgent care)	Plan pays 100% following $20 co-pay per visit or exam and deductible. *For outpatient mental health and substance abuse care in an outpatient hospital setting, refer to the outpatient hospital benefit.* *(Maintenance services excluded)* Precertification notice recommended.	Plan pays 80% of UCR charges following $25 co-pay per visit or exam and deductible. *For outpatient mental health and substance abuse care in an outpatient hospital setting, refer to the outpatient hospital benefit.* *(Maintenance services excluded)* Precertification notice recommended.

Covered Benefit	In Network	Out-of-network
Preventive Services as defined under the Patient Protection and Affordable Care Act (PPACA)	Plan pays 100% (no co-pay or deductible).	Plan pays 80% of UCR charges following $25* co-pay and deductible.
	Includes but is not limited to: • Routine Physical Exam (one per Calendar Year) Well baby exams up to age 2 • Routine Gynecological Exam • Specific Immunizations • Routine Colonoscopy • Routine Sigmoidoscopy • Routine Mammogram • Routine Cholesterol or glucose screening (when not tied to a Diagnosis) *(See "Preventive Benefits Covered Under PPACA" handout for details or contact Plan Supervisor)* *Out of network Co-pay waived for one routine physical exam or school required exam per Year, one gynecological exam per Year, well-baby exams up to age 2, routine immunizations and vaccines, injectable birth control, x-ray and lab and technical and professional physician testing services (interpretive services of pathologists and radiologists) including screenings such as mammography, pap smear, colonoscopy and prostate screenings.	
Physician	Plan pays 100% following $20 co-pay per visit or exam and deductible. Applies to in-network Urgent Care visits within the state of WI	Plan pays 80% of UCR charges following $25 co-pay per visit or exam and deductible. Applies to out of network Urgent Care visits within the state of WI For Urgent Care visits outside of the state of WI: Plan pays 100% following a $75 co-pay per visit or exam and in-network deductible. For Emergency In-Patient services, after a $20 co-pay per visit or exam and in-network deductible the Plan pays 100% of billed amount for services originating after the hospital outpatient emergency department through any immediately succeeding inpatient stay.
	Co-pays waived for x-ray and lab including diagnostic screenings, pathologists, radiologists, anesthesiologists, non-physician rehabilitation therapy and non-physician allergy services.	
Skilled Nursing Facility	Plan pays 100% following the deductible. Precertification notice recommended.	Plan pays 80% of UCR charges following the deductible. Precertification notice recommended.
	Maximum benefit of 60 days per Covered Person per Calendar Year combined for in network and out-of-network charges.	
SmartChoiceMRI	Plan pays 100% for covered services obtained at a SmartChoiceMRI location. Precertification notice recommended.	See Diagnostic x-ray Row on Page 2.
Surgeon	Plan pays 100% following $20 co-pay per visit or exam (when a separate exam or visit fee is billed) and deductible.	Plan pays 80% of UCR charges following $25 co-pay per visit or exam (when a separate exam or visit fee is billed) and deductible.
	Co-pay waived for x-ray and lab technical and professional physician testing services (interpretive services of pathologists and radiologists), and anesthesiologist services. Precertification notice recommended for surgery when performed outside of a physician's office (other than diagnostic endoscopies such as colonoscopy).	
Therapy Services for Disability (Non-Physician) **Physical, occupational, speech, therapy, radiation, chemotherapy, dialysis treatments, respiratory, Cardiac rehabilitation phases I & II**	Plan pays 100% following deductible. *(Maintenance Services are excluded)* Precertification notice recommended.	Plan pays 80% of UCR charges following deductible. *(Maintenance Services are excluded)* Precertification notice recommended.
Vision Exam - Routine	Plan pays 100% following $10 co-pay and deductible.	Plan pays 80% of UCR charges following $10 co-pay and **in network** deductible.
	Limited to one per Covered Person per Calendar Year (by physician or optometrist).	

COVERED RETIRED EMPLOYEES with a permanent residence outside of the state of Wisconsin will have coverage for out-of-NETWORK providers generally covered at 100% of the billed amounts not to exceed the PREVAILING FEE level for such type of service after application of co-pay amounts and deductible. Retirees and surviving spouses/dependents of retirees whose permanent residence is in the state of Wisconsin must see in network providers to be considered in network participants.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS
(*Formulary* Applies)

IN NETWORK RETAIL CO-PAYMENT STRUCTURE **Plan deductible and co-insurance do not apply to the Prescription Drug Benefits**	
Generic medication co-payment per formulary prescription (including formulary insulin and diabetic supplies)	$10 for up to 30 day supply
Brand name medication co-payment per formulary prescription	$20 for up to 30 day supply
If a Covered Person elects a formulary brand name medication when a generic-equivalent medication is available, the copay is 40% of the formulary brand name prescription price not to exceed $30 for each 30-day supply, unless such brand name medication is determined to be medically necessary. If a non-formulary medication is selected, the member pays 100% of the cost of the medication.	
MAIL ORDER CO-PAYMENT STRUCTURE (Mandatory Mail-Order of Maintenance Drugs)	
Generic maintenance medication co-payment per formulary prescription (including formulary insulin & diabetic supplies)	$20 for up to 90 day supply
Brand name maintenance medication co-payment per prescription	$40 for up to 90 day supply
If a Covered Person elects a formulary brand name medication when a generic-equivalent medication is available, the copay is 40% of the formulary brand name prescription price not to exceed $60 for each 90-day supply, unless such formulary brand name medication is determined to be medically necessary. If a non-formulary medication is selected, the member pays 100% of the cost of the medication.	

Notes:

This Schedule of Prescription Drug Benefits is a summary of your benefits. Please review specific plan provisions within the Master Plan/Summary Plan Document to ensure you understand the complete benefits.

There is a maximum out of pocket (MOOP) of $8,700 Individual / $17,400 Family which includes Prescription drug co-payments and the medical benefit plan deductible, co-insurance, co-payments (when applicable) when incurred in network.

When a prescription is covered for a chronic medical condition, a covered person is allowed an initial trial period at a retail store (for up to a two (2) 30-day supplies) to confirm the drugs compatibility and effectiveness. Thereafter coverage for designated maintenance type drugs is limited to such home delivery method (including oral birth control, but does not apply to insulin or diabetic supplies).

Precertification (prior authorization) may be required for certain types of medications.

Out-of-Network prescription drugs are generally NOT covered. However, coverage may be available if: a) an allowable specialty drug is not available from a Network and is therefore obtained Out-of-network or b) in connection with emergency services when it is not reasonable to obtain from a Network pharmacy. Such Out-of-network claims must be paid by the covered participant at the point of service and then submitted by the covered participant to the prescription drug *Plan Supervisor* for reimbursement.

Excluded drugs *(Refer to the Prescription Drug Exclusion Section for a complete list of exclusions)***:**

a. for sexual dysfunction (other than related to organic disease or directly caused by prior allowable surgery)
b. for infertility
c. for services determined to be experimental or not of established medical value, and
d. for which a comparable over-the-counter drug is available (such as nutritional supplements and when the FDA ends the status of requiring a prescription for a drug)