Summary of Proposed Changes to the City of La Crosse
Medical Plan Master Plan Document/Summary Plan Description

1) Effective date of coverage: change from the 1st of month following two months of employment to the 1st of the month following one month of employment.
2) Timely notice of claims: change from 16 to 12 months.
3) LiveHealth Online mental health video visits: Cover at no cost to the member.
4) Private hospital room: remove language that limits the cost of the private when a semiprivate room is not available.
5) Transplants: remove the specific list of transplants covered and replace with language stating that transplants are covered that are medically necessary and non-experimental/investigational in nature and include examples without limiting to such examples.
6) Skilled nursing: remove language that requires admission must occur within 24 hours of release from an acute care facility.
7) Home health care: remove language regarding the maximum weekly allowance.
8) Hospice care: remove 180 visit limit.
9) CPAP/BIPAP: remove specific criteria as medical review organization determines medical necessity.
10) Remove exclusion for use of off-label medications.
11) Nutritional counseling: change to cover when medically necessary instead of listing specific conditions that allow coverage.
12) Services and supplies associated with low or declining physical or mental functioning: remove exclusion for coverage of such.
13) Continuous glucose monitors and disposable insulin delivery devices: adding coverage under the prescription drug benefit (one per year).
14) Coordination of benefits: delete paragraph.
15) Add a second level appeal process.
16) Adding a voluntary Specialty Drug Program (CAAP Rx).
17) Recital: Delete paragraph referring to reverting back to plan provisions prior to 2012 if certain federal or state laws are repealed.

Summary of changes to be made to be consistent with state and federal laws or to be consistent with existing plan language:

1) Add statement that the plan will be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan and that it's the intent of the plan that it conforms to various applicable laws.
2) Remove sentence stating that outpatient mental illness or chemical dependency for more than five visits needs pre-certification to comply with mental health parity.
3) Remove sentence that states that the disease, trauma or therapeutic process must have occurred after the participant's effective date and that transsexual surgery is excluded from coverage.
4) Modify language for surgical treatment of gender dysphoria to comply with mental health parity.
5) Remove and add language regarding prescription drug coverage for treatment of gender dysphoria.
6) Add language and government websites under Routine Care.
7) Update language to allow for non-legend medications to be covered when mandated under Affordable Care Act.
8) Remove exclusion for charges in relation to use of illegal drugs or medications to comply with HIPAA's non-discrimination requirements.
9) Update language for exclusion of penile prosthesis implants to allow for coverage for medically necessary services relating to sex reassignment surgery for gender dysphoria.
10) Add Department of Labor recommended language regarding other coverage options besides COBRA.
11) Modify sentence regarding preventive services as defined by ACA to refer to a website for detailed information or for member to contact PBA for more information.
12) Increase the Maximum Out of Pocket to the 2023 rate.
13) Add language regarding the No Surprises Act (protection from surprise billing).

Proposed Changes to the City of La Crosse
2023 Master Plan Document/Summary Plan Description

1) **Effective date of coverage – New Employees – page 42. The document reads:**

As a new *employee*, *You* shall become eligible for coverage effective on the first day of the calendar month following ~~two~~ one (~~2~~1) full calendar month~~s~~ as an *employee* provided *You* are in *active status* and/or employed on that date. ~~*Note that if this results in a waiting period exceeding 90 days, such effective date shall revert to the 1st*~~

2) **Timely Notice of Claim – page 7. The document reads:**

TIMELY NOTICE OF CLAIM
Claims must be submitted as soon as possible after the date of the expense was incurred. In no event will a claim be accepted and paid beyond ~~sixteen~~ twelve (~~16~~12) months from the date of expense. In the event that a provider fails to submit a bill with complete information, *you* must act to provide such information to the *Plan Supervisor* in order to meet the ~~sixteen~~ twelve month deadline

3) **Coverage for Anthem's LiveHealth Online Video Visit with a license therapist or board-certified psychiatrist – found within Schedules of Benefits pages 105, 111, 117 & 123. Coverage currently applies applicable cost sharing (copay, deductible and co-insurance). Proposal to pay at 100%.**

4) **Hospital Inpatient Benefits – page 10.** The document reads:

The maximum eligible charge for non-intensive private room will not exceed the daily rate for the greatest number of semiprivate rooms in the hospital where confined. If the Hospital does not provide a semiprivate room for the particular hospital stay, the private room rate will be covered. ~~*allowance shall not exceed the lesser of:*~~
~~*a. The charge for the particular room occupied; or b. The average daily charge for all two-bed rooms in the area.*~~

5) **Exclusions – page 37.** The document reads:
~~*No benefits will be paid for charges related to whole organ transplants or artificial hearts, except to the extend the Plan provides coverage for initial human kidney, kidney/pancreas, corneal (keratoplasty), limited bone marrow applications, heart, heart/lung, liver, lung, musculoskeletal, and parathyroid transplants for recipients who are plan participants;*~~
Transplant coverage is limited to those transplants that are medically recognized and are non-experimental/investigational in nature. Examples of covered transplants would be, but not limited to: *human kidney, kidney/pancreas, corneal (keratoplasty), limited bone marrow applications, heart, heart/lung, liver, lung, musculoskeletal, and parathyroid transplants for recipients who are plan participants.*

6) **Skilled Nursing Facilities – page 19. The document reads:**
Limitations: The participant is entitled to a maximum of 60 days per calendar year. ~~Admission must occur within 24 hours of release from an acute care facility and~~ must be in lieu of continued hospital stay.

7) **Home Health Care – page 21. The document reads:**
~~*The maximum weekly allowance for home care coverage will not exceed the usual and customary weekly cost for care in a skilled nursing facility*~~.

8) **Hospice Care – page 22. The document reads:**
~~Hospice Care Benefits are limited to 180 daily visits per lifetime.~~.

9) **Durable Medical Equipment includes the following– page 26. The document reads:**

J. CPAP/BIPAP ~~is eligible when one of the following~~ criteria applies:
~~i. *Participant* has a diagnosis of obstructive sleep apnea syndrome (as defined as apneahypopnea index (AHI) or respiratory disturbance index (RDI) greater than 20 or an apnea-hypopnea index (AHI) or respiratory index (RDI) greater than 10 and daytime hypersomnolance objectivity documented by:~~
~~1) A multiple Sleep Latency Test (MSLT) showing a mean sleep latency of less than 10 minutes and a sleep diary indicating an average of 7 hours or greater of sleep a day; or~~
~~2) An Epworth score of 10 or greater minutes and a sleep diary indicating an average of 7 hours or greater of sleep a day.~~

ii. *Prescription* CPAP/BIPAP is written by a pulmonologist or a sleep disorder *specialist*.
iii. Initial prior authorization approval will be for one month. Follow up with the pulmonologist will be required for additional rental or for the rent-to-purchase option.

10) Experimental Exclusion – item 17, b. – page 34. The document excludes:

b. drugs, tests, and technology which:
i. the FDA has not approved for general use;
ii. are considered Experimental;
iii. are for investigational use; or
iv. are approved for a specific medical condition but are applied to another condition.

11) Nutritional Counseling Exclusion/Limitation 58 Page 37, The document reads:

No benefits will be paid for nutritional counseling unless medically necessary and under the supervision of or provided by a registered dietician. except to the extent the Plan provides coverage for morbid obesity, cancer, diabetes, heart disease, high blood pressure, anorexia nervosa or bulimia or as required under law

12) Exclusion #60 - Page 37. The document reads:
No benefits will be paid for services and supplies associated with the following conditions, including for low or declining physical or mental functioning compared to the normal range that may be due to conditions such as aging, gender, personal choices of lifestyle (such as poor exercise, poor diet, obesity other than morbid obesity), emotional or interpersonal conditions (other than defined as mental illness).

13) **Prescription Drug Benefits covered benefits – page 39.** The document reads
For diabetic management: Insulin; disposable insulin needles, lancets, syringes; and disposable blood, urine, pump supplies, swabs, glucose and acetone testing agents/test strips and sensors. Continuous glucose monitor and disposable insulin delivery device can be obtained under pharmacy benefit and are limited to one per calendar year for diabetic management.

14) Coordination of Benefits – page 58. The document reads:
When the City Plan is the Secondary Plan, it shall credit back to a plan participant any copay and/or co-insurance amounts applied per service encounter and annual deductible amounts it would have applied and charged during a year against the amount due for such plan participant during such year in the absence of another coordinating plan. Any amount initially saved by the City Plan for a plan participant (other than plan savings related to drug benefits) is accumulated in a COB credit account for such plan participant. When such credit amounts exist and a claim service line is processed where the allowable expense is not met by the combined benefits of other coordinating plans, the unpaid amount is taken from such credit savings of the plan participant and is used to pay up to the allowable expense not otherwise payable – common copay amounts applied per service encounter, co-insurance, annual deductible amount, and copay percentage amounts.

15) Appeals – pages 68-74 . Add a second level appeal on page 72 using the language below.

Second Level Appeal

Request for Review
Upon completion of the first level of appeal, any claimant who has been affected by a decision to deny a claim for benefits, a utilization review decision, or a rescission of coverage determination, or who believes the action determining the amount of benefits to be paid is improper, may submit a written request to the Plan Supervisor to review the claim.

The written request must be submitted to the Plan Supervisor within ninety (90) days after receipt of the Plan's decision on the first level of appeal. The request shall be accompanied by any evidence and argument the claimant wishes to present.
When requesting a review, the claimant should state the reasons the claimant believes the denial was improper and submit any additional information, material, or comments which the claimant considers appropriate.

Review

Upon timely receipt of a request for review, the Plan Supervisor will schedule a review of the claimant's appeal. If any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan Supervisor will provide that information to the claimant free of charge and sufficiently in advance of the due date of the response to the claimant's appeal. If such evidence is received at a point in the process where the Claims Review Committee is unable to provide the claimant with a reasonable opportunity to respond prior to the end of the time period stated below, the time period will be extended
to allow the claimant a reasonable opportunity to respond to the new or additional evidence.

Timing of Notification of Benefit Determination on Second Appeal

The Plan Supervisor will notify the claimant of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Urgent Care Claims. As soon as possible, taking into account the medical exigencies, but not later than 36 hours after receipt of the second appeal.
2. Pre-service Non-urgent Care Claims. Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the second appeal.
3. Concurrent Claims. The response will be made in the appropriate time period based upon the type of claim – Pre-service Urgent, Pre-service Non-urgent or Post-service.
4. Post-service Claims. Within a reasonable period of time, but not later than 30 days after receipt of the second appeal.
5. Calculating Time Periods. The period of time within which the Plan's determination is required to be made will begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

The written decision of the Plan Supervisor shall be based on the record at the review and shall be final, except as otherwise required by law.

16) Schedule of Prescription Drug Benefits – pages 113, 119, 125 and 131. Add the following language:
Specialty Drugs – (CAAP Rx Program)

Specialty medications obtained through the Serve-You CAAP Rx Program, a significant portion (or possibly all) of your copayment will be paid by the manufacturer program.

Any manufacturer funded copayment assistance received under the CAAP Rx program does not apply toward the member's annual out-of-pocket maximum. Copayment assistance programs offered by drug manufacturers may be changed at any time by the drug manufacturer and the benefit provided by CAAP Rx will adjust accordingly

17) Recitals – page 1. Update as follows:
RECITALS

City of La Crosse (City), a Wisconsin municipality, hereby establishes its self-funded Medical Benefit Plan (Plan) for the benefit of eligible Employees, Retirees, and their eligible Dependents. The benefits described in this document are ***not*** conditions of employment, nor are they meant to establish a contract between City and its Employees. Neither enrollment nor anything contained in this Plan shall give any Employee the right to be retained in the employ of City nor shall it interfere with the right of City to discharge any Employee at any time.

This document constitutes the entire Plan and supersedes all the prior Plan documents. ~~To the extent the Plan document has been changed, the intent of the change is to incorporate required new Federal Legislative changes such as those due to the Patient Protection and Affordable Care Act, HIPAA, etc. Additionally, any new Wisconsin State Statutory requirements have been incorporated. However, in the event the Federal or State of Wisconsin law requiring any plan provision shown is repealed or amended at any time, the City has the right to revert to any previous provision that is allowed by law.~~

~~**Document amended to reflect new 2022 claims administrator & to update the Maximum out of pocket limits under the ACA to 2022 limits..*~~

The following changes are to be made to the 2023 City of La Crosse MPD/SPD to comply with State and Federal laws and/or to be consistent with other plan document provisions:

1) **Update the following language under "An Important Message About Your Plan" - page 4:**
~~The City of La Crosse Medical Benefit Plan, restated January 1, 2012 shall be amended as described herein.~~ ~~***However, in the event the Federal or State of Wisconsin law requiring these amendments is repealed or amended at any time, the affected provision(s) will revert to the provision in the Plan that was in existence immediately prior to this change.***~~

Conformity with Law
This Plan will be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions, or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Supervisor to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Master Plan Document/Summary Plan Description. It is intended that the Plan will conform to the requirements of Federal civil rights laws and ACA, as it applies to group health plans, as well as any other applicable law.

2) **On the List of pre-certifications page 5:** Take out the following sentence:
~~*"Outpatient mental illness or chemical dependency for more than five visits per calendar year"*~~

3) **Surgical Services – Reconstructive Surgery – page 12. The document reads:**
Reconstructive surgery: surgery to restore bodily function or correct deformity resulting from disease, trauma, or a previous therapeutic process that is a covered service under this Plan. This includes coverage for surgery subject to the provisions of the Women's Health and Cancer Rights Act. ~~*The disease, trauma, or therapeutic process must have occurred after the participant's effective date and while the participant is continuously covered under the Plan. Transsexual Surgery is excluded from coverage*~~.

4) **Surgical Services – Services Related to Gender Change – page 14. The document reads:**
Services related to a gender change: Members diagnosed with gender dysphoria who meet all of the required clinical criteria as determined by the Plan Supervisor, may be eligible for gender reassignment services or coverage for the treatment of gender dysphoria ~~only after receiving approval in advance of the treatment.~~ The Plan Supervisor has specific policy guidelines which may further limit treatment or benefits. This provision does not otherwise expand coverage to benefits that are specifically excluded under the policy guidelines or elsewhere under this document.

5) **Limitations and exclusions for prescription drug benefits #6 -page 39. The document reads:**

~~Progesterone or hormones related to gender transformation in any compounded dosage form except as follows: Members diagnosed with gender dysphoria who meet all of the required clinical guidelines as determined by the Plan Supervisor, may be eligible for progesterone or hormones related to gender dysphoria or gender reassignment surgery only after receiving approval in advance of the treatment. The Plan Supervisor has specific policy guidelines which may further limit treatment or benefits. This provision does not otherwise expand coverage to benefits that are specifically excluded under the policy guidelines or elsewhere in this document.~~

Add the following language under Prescription Drug covered benefits – page 39 :

Treatment for gender dysphoria.

6) **Routine Care – page 17. Add the following language:**

Routine care includes preventive services for screenings for plan participants when determined to be appropriate for related health risk include but are not limited to the services listed below. Additional information about Preventive Care services required under the Affordable Care Act (ACA) is available at the following government websites:

https://www.healthcare.gov/coverage/preventive-care-benefits/;
https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/;

https://www.cdc.gov/vaccines/hcp/acip-recs/index.html;

https://www.aap.org/en-us/Documents/periodicity_schedule.pdf;

https://www.hrsa.gov/womensguidelines/.

7) **Page 40, Prescription Drugs – Exclusion 12. The document excludes:**
Non-legend drugs~~.~~ except those mandated for coverage by the Affordable Care Act.

8) **Illegal Drugs or Medications Exclusion – page 37. The document reads:**
~~*50. Charges in relation to use of illegal drugs or medications*~~.

9) **Section III Limitation and Exclusions #49 – page 37. The document reads:**
Charges for penile prosthesis implants and any charges relating thereto~~.~~except: to the extend the Plan provides coverage for medically necessary services relating to sex reassignment surgery for treatment of gender dysphoria.

10) **Section VI Termination and Continuation, COBRA section - pages 51-56. Add the language below to page 52.**

Are there other coverage options besides COBRA Continuation Coverage?

Instead of enrolling in COBRA Continuation Coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation Coverage. You can learn more about many of these options at www.healthcare.gov .

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer), and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you .

11) **Preventive Services as defined under PPACA on Schedules of Benefits pages 106, 112, 118 & 124.**
Document reads:
~~(See "Preventive Benefits Covered Under PPACA" handout for details or contact Plan Supervisor.)~~ A list of Preventive Care services required to be covered at no cost under the PPACA can be found at www.healthcare.gov/coverage/preventive-care-benefits/ or member can contact the Plan Supervisor for more information.

12) **Maximum Out of Pocket (MOOP) listed on Schedules of Benefits pages 103, 107, 109, 113, 115, 119, 121 & 125.** Update numbers to reflect 2023 Maximum Out of Pocket under ACA of $9,100 and $18,200.

13) **No Surprises Act – add the following new language on page 9:**

PROTECTION FROM BALANCE BILLING

This section is to be interpreted in accordance with the No Surprises Act. Covered health care services that are subject to the No Surprises Act requirements will be reimbursed according to this section.

Emergency health care services provided by an out-of-network provider will be reimbursed as set forth under Allowed Amounts below.

Covered health care services provided at certain network facilities by out-of-network qualified practitioners, when not emergency health care services, will be reimbursed as set forth under Allowed Amounts below. For these covered health care services, the term "certain network facility" is limited to a hospital, a hospital outpatient department, a critical access hospital, an ambulatory surgical center, and any other facility specified by the Secretary of Health and Human Services.

Air ambulance transportation provided by an out-of-network provider will be reimbursed as set forth under Allowed Amounts below.

ALLOWED AMOUNTS

For covered health care services that are ancillary services received at certain network facilities on a non-emergency basis from out-of-network qualified practitioners, You are not responsible, and the out-of- network provider may not bill You for amounts in excess of Your co-payment, coinsurance or deductible based on the Schedule of Benefits applicable to You found within this Master Plan Document/Summary Plan Description.

For covered health care services that are non-ancillary services received at certain network facilities on a non-emergency basis from out-of-network qualified practitioners who have not satisfied the notice and consent criteria, or for unforeseen or urgent medical needs that arise at the time a non-ancillary service is provided for which notice and consent has been satisfied as described below, You are not responsible, and the out-of-network provider may not bill You for amounts in excess of Your co-payment, coinsurance, or deductible based on the Schedule of Benefits applicable to You found within this Master Plan Document/Summary Plan Description.

For covered health care services that are emergency health care services provided by an out-of-network provider, You are not responsible, and the out-of-network provider may not bill You for amounts in excess of Your applicable co-payment, coinsurance or deductible based on the Schedule of Benefits applicable to You found within this Master Plan Document/Summary Plan Description.

For covered health care services that are air ambulance transportation services provided by an out-of-network provider, You are not responsible, and the out-of-network provider may not bill You for amounts in excess of Your applicable co-payment, coinsurance or deductible based on the rates that would have applied if the service had been provided by a network provider and on the Schedule of Benefits applicable to You found within this Master Plan Document/Summary Plan Description.

Allowed amounts are determined in accordance with the Plan Administrator's reimbursement contracts or as required by law, as described in this Master Plan Document/Summary Plan Description.