MEDICAL BENEFIT PLAN SUMMARY

Applicable to Employees Represented Under Employee Handbook, Library, LPPNSA & LPPSA & IAFF Employees hired on/after 7/1/11

To follow is a *brief* summary of current 2024 benefit. *Please refer to the Schedule of Benefits and/or Master Plan Document/Summary Plan Description for complete details. These documents, the Summary of Benefits and Coverage, and other benefit related information and links can be found at* www.cityoflacrosse.org/hr/eebenefits.

2024 Monthly Contribution Amount *(subject to Council approval 11/13/23)*

Plan Type	Monthly Rate if did 2023 Health Risk Assessment (12.6% of plan cost)	Monthly Rate if did not do 2023 Health Risk Assessment (16% of plan cost)
Single	$84.12	$106.82
Limited Family (2 person)	$173.98	$220.94
Family	$211.80	$268.94

Brief Summary of Out of Pocket Costs– Please refer to the Schedule of Benefits for More Details

Provision	Coverage
Annual deductible	In-Network: $400 per Person/maximum of $1,200 per Family Unit. Out-of-Network: $800 per Person with no Family Unit maximum. *Exception: Ambulance or Emergency Room services paid at the in network rate even when provider is out of network.
Co-insurance after deductible is met (Any Co-pay is additional)	In-Network: Plan generally pays 90% & Member pays 10% with an annual maximum out of pocket to Member of $600 per Person /$1,800 per Family Unit. Once this maximum is met, the plan pays 100% (co-pay and fixed dollar or visit limits, when applicable, would still pertain). Out-of-Network: Plan generally pays 70% & Member pays 30%.
Office Visit Co-pay **ER Co-pay** **Chiropractic Co-pay** **Convenience/Retail Clinic Visit**	In-Network / Out-of-Network $20 per visit or exam / $25 per visit or exam $75 (waived if admitted within 24 hours) / (same as in network) $20 per daily visit or exam / $25 per daily visit or exam No Cost to Member / 20% co-insurance
Preventive Services as defined under the Patient Protection and Affordable Care Act (ACA)	In-Network: Plan pays 100% Out-of-Network: $25 co-pay then Plan pays 70% of UCR charges following the Out-of-Network deductible. Includes but is not limited to: Routine Physical Exam, Well baby exams up to age 2, Routine Gynecological Exam, Specific Immunizations, Routine Colonoscopy, Routine Mammogram, Routine Cholesterol or glucose screening (when not tied to a Diagnosis)
Covered Services at the Neighborhood Family Clinic **Anthem's LiveHealth On-line** (Video Visits with Board-Certified Doctor, Psychiatrist or Licensed Therapist)	At no cost to member (no deductible, co-pay or co-insurance).
Rx Drug Co-pays	Formulary Generics: $10 retail (30 day supply) / $20 mail order (90 day supply) $30 (90 day at retail) Formulary Brand: $25 retail (30 day supply) / $50 mail order (90 day supply $75 (90 day at retail) Specialty Medications: $50 (30 day supply) **90 day mail order (2 copays) OR 90 day at retail (3 copays) required for Maintenance Drugs after first two 30 day retail fills*.

**If there are any discrepancies between this and the MPD/SPD, the MPD/SPD prevails.*

Note: When processing claims, the plan would apply cost sharing in the following order.

1) ***Co-pay*** *if the claim is for a physician visit, Behavioral Health visit, ER, Chiropractic or Routine Eye Exam.*
2) ***Deductible*** *(unless individual or family max is met)*
3) ***10% Co-insurance*** *(unless individual or family max is met)*

A list of Preventive Care services required to be covered at no cost under the ACA can be found at www.healthcare.gov/coverage/preventive-care-benefits/ or member can contact the PBA at 1-800-435-5694 for more information.