Frequently Asked Questions Regarding the Medical Benefit Plan

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1) *Q: Where can I find information on what is covered under the medical plan?*
   A: The Master Plan Document/Summary Plan Description (MPD/SPD) is the document that contains all of the details regarding the City's Medical Benefit Plan (coverage, eligibility, exclusions, HIPAA, COBRA, appeal rights, etc). It can be found directly at www.cityoflacrosse.org/hr/eebenefits or at www.cityoflacrosse.org under "Your Government", "HR" then "Employee Benefits". A hard copy can be obtained from the City HR office.

2) *Q: Who administers the medical plan?*
   A: The City hires third party administrators to perform administrative functions such as paying claims, utilization review and customer service for its self-funded medical benefit plan.

   Medical plan administrator: *Professional Benefits Administrators (PBA).*
   1-800-435-5694 www.pbaclaims.com
   Prescription Drug plan administrator:
   Serve You Rx
   1-800-759-3203 www.serve-you-rx.com

3) *Q: What is meant by "network" and how do I know if my provider is in the network?*
   A: The administrator, PBA, partners with Anthem Blue Cross Blue Shield for access to Anthem's nationwide & international network. Anthem's network is a list of facilities, providers and suppliers that contract with Anthem and agree to lower pricing. For example, in this area Gundersen Health System and Mayo Health System facilities and medical staff are all in network. Members are encouraged to check the network for other providers (including chiropractors and suppliers of durable medical equipment) using PBA's member portal (containing a link to Anthem' site to search their network) or the instructions found at www.cityoflacrosse.org/hr/eebenefits.

4) *Q: What is the "Maximum Out of Pocket" of $9,450/$18,900 that is listed on my 2024 ID card, my Explanation of Benefits or on the Schedule of Benefits?*
   A: Under the Affordable Care Act, health plans are required to have the Maximum Out of Pocket often referred to as a MOOP. Under the law, if a covered person would ever reach that much in out of pocket costs from in network services, the plan would then be required to pay 100%. It would be almost mathematically impossible for a member under the City's plan to have that much out of pocket as the members' in network out of pocket would consist of their deductible, co-insurance (if applicable to their plan) and copays (i.e. physician, ER, chiropractic or prescription drug).

5) *Q: How long can my child stay on the plan?*
   A: Dependents are eligible until the end of the month in which they turn age 26 regardless of marital status, school status or whether or not you support them. A dependent with a total and permanent disability (as defined in the Master Plan Document) can continue coverage beyond age 26.

6) *Q: Are routine vision exams covered under the medical plan?*
   A: Yes. Routine vision exams are covered as follows and are limited to one per calendar year:
   All plans except ATU: In network: $10 Copay / Deductible / 10% Co-insurance
   Out of network: $10 Copay / In net Deductible / 30% Co-insurance
   ATU plan: In network: $10 Copay / Deductible
   Out of network: $10 Copay / In net Deductible / 20% Co-insurance

7) *Q: Is a shingles shot covered?*
   A: Yes. The Shingrix shingles vaccination is covered at no cost when obtained at your in network provider.

8) *Q: Are continuous glucose monitors & sensors for diabetes management covered under the plan?*
   A: Yes, they can be obtained through <u>either</u> the medical plan through an in network durable medical equipment provider or new in 2023 they can be obtained through your pharmacy benefit at a retail pharmacy with a tier 2 copayment. A prescription and a Prior Authorization is required.

9) *Q: Is the "Cologuard" or "FIT" test covered?*
   A: Yes, it would be covered at no cost if ordered by your in network doctor and if it is coded as a preventive screening. If due to the test a member then requires a colonoscopy, the colonoscopy would be subject to cost sharing as it would be based on a diagnosis and no longer preventive.

10) *Q: Is a colonoscopy covered?*
   A: One <u>routine</u> colonoscopy is covered per year without cost to the member when obtained in network. Removal of polyps and the pathology charge as a result of the routine colonoscopy would also be covered without cost to the member.   IF the lab/pathology claim has cost sharing applied for a routine colonoscopy, please call PBA to request that they review the claim to reprocess at 100%.

11) *Q: Can I go to the Neighborhood Family Clinic for services?*
   A: Employees/Retirees, spouses and dependents that are enrolled in the medical plan can obtain services at the Neighborhood Family Clinic (NFC) at no cost. Exception: the NFC benefit is not available for those covered under the ATU plan. Note that the La Crosse & Onalaska NFC locations share office space with Breidenbach Chiropractic, however, they are not a part of the NFC and their services would fall under the member's normal benefit (co-pay, deductible, etc).   Reminder: Anthem's LiveHealth Online (video doctoring) and Gundersen's Express Care are also available at no cost to covered members.

12) *Q: Does the medical plan cover any oral surgeries or dental related services?*
   A: Yes. The plan covers 16 different oral surgeries as well as the following services as listed in the MPD/SPD (note cleanings, fillings, basic dental services including crowns except where noted below are not covered under the medical). Services for a & b below are limited to $3,000/year.

   a. *Root canal therapy and related filling, or crown within six months thereafter regardless of whether such crown was necessary due to such tooth being defective at such time.*
   b. *Major Restorative: Simple non-cutting extraction of a natural erupted tooth with the initial replacement with an artificial tooth including initial partial dentures or bridgework when such replacement is functionally necessary for each extracted tooth.*
   c. *Repair or replacement of a natural tooth due to injury by blunt external force other than chewing within six months of such injury, when such replacement is functionally necessary.*
   d. *Surgical exposure or removal of impacted un-erupted teeth.*

   Due to the shortage of in network providers that perform services under "a", "b" or "c" above, out of network claims are paid at the in network level at this time by exception. The medical plan would be primary over the City's voluntary dental plan (for members enrolled in the City's Dental Insurance).

13) *Q: Is there a form that I need to complete to add a new family member to the plan (i.e. marriage/birth-adoption of a child).*
   A: Yes. Employees/Retirees need to complete and submit an enrollment form to HR within 31 days of event (marriage or birth/adoption of a child) to add a new spouse (and/or dependents) to their existing coverage. Please contact HR for a benefit packet which includes the enrollment form.

**See the MPD/SPD for complete details. If this summary and the MPD/SPD conflict, the MPD/SPD will control.*