<u>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:</u>

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as described herein.~~ ~~***However, in the event the Federal or State of Wisconsin law requiring these amendments is repealed or amended at any time, the affected provision(s) will revert to the provision in the Plan that was in existence immediately prior to this change.***~~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.

Reason for change: Stated elsewhere in less detail so it is recommended by USI & PBA to add this more detailed statement.

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"*~~

Reason for change: Under Mental Health Parity, non-quantitative treatment limitations that apply to mental health / substance abuse must be comparable to those that apply to medical/surgical benefits. Since there is not a similar requirement for medical/surgical visits, this limit should be removed.

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*~~.

Reason for change: HIPAA defines a pre-existing condition exclusion as "a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage". Therefore, limiting coverage to only conditions that occur after the participant's effective date, is a pre-existing condition exclusion that is not permitted. In addition, the transsexual surgery exclusion should be removed. The exclusion conflicts with the Plan's coverage for gender reassignment services for treatment of gender dysphoria.

4) **Surgical Services – Services Related to Gender Change – page 14. The document reads:**

<u>Services related to a gender change</u>: 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.

Reason for change: USI and PBA recommend taking out as to avoid potential discrimination or Mental Health Parity compliance issues.

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.

Reason for change: Coverage for such medications would be based on medical necessity and USI and PBA recommend taking the above language out and to add new language in to avoid potential discrimination or Mental Health Parity compliance issues.

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/.

Reason for proposed change: USI and PBA recommend adding resources for members to obtain detailed information on the services required under the ACA to be provided at no cost to the member.

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

Reason for change: The Affordable Care Act mandates that specific non-legend drugs be covered under the plan.

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

Explanation for proposed change: Exclusions and limitations for injuries resulting from misuse of drugs or alcohol must comply with HIPAA's nondiscrimination requirements which prohibit denial of benefits otherwise provided for treatment of an injury under a source-of-injury exclusion if the injury results from domestic violence or a medical condition (e.g., alcoholism), even if the condition was not diagnosed before the injury.

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.

Reason for change: exception necessary for covered service listed in the MPD/SPD of sex reassignment surgery for the 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 .

Reason for change: Although this language is not required as it's supplied by the City to participants in a separate mailing, it would be good to offer the information within this document as well.

11) **Preventive Services as defined under ACA 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 ACA can be found at www.healthcare.gov/coverage/preventive-care-benefits/ or member can contact the Plan Supervisor for more information.

Reason for change: A handout is no longer maintained so members are directed to the website or can contact the Plan Supervisor.

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:**
Reason for change: New law and it is recommended by PBA & USI to include in the document.

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.