

ADDENDUM A

Retiree Medical Benefit Plan Coverage - Normal Service

Group	Hire date	Years of Service Required
Police Non-Sups (LPPNSA Local #26)	Hired as of 6/30/2004	15 years of full time continuous service
	7/1/2004 - 12/31/2006	18 years of full time continuous service
	1/1/2007 - 6/30/2013	20 years of full time continuous service
	Hired on or after 7/1/2013	Not eligible
Police Supervisory (LPPNSA Local #91)	Hired as of 6/30/2004	15 years of full time continuous service
	7/1/2004 - 12/31/2006	18 years of full time continuous service
	1/1/2007 - 6/30/2013	20 years of full time continuous service
	Hired on or after 7/1/2013	Not eligible
Fire (IAFF Local #127)	Hired as of 6/30/2004	15 years of full time continuous service
	7/1/2004 - 12/31/2006	18 years of full time continuous service
	1/1/2007 - 6/30/2013	20 years of full time continuous service
	Hired on or after 7/1/2013	Not eligible
Transit (ATU Local #519) (Full time employees)	Hired as of 6/30/2004	10 years of continuous employment with City
	7/1/2004 - 12/31/2006	15 years of full time continuous service
	1/1/2007 - 12/31/2013	20 years of full time continuous service
	Hired on or after 1/1/2014	Not eligible
Non-Represented, SEIU (EE Handbook)*; and Library	City Executives	
	Hired prior to 1/1/2014	10 years of continuous employment
	Hired on or after 1/1/2014	Not eligible
	Non-City Executives	
	A. General	
	Hired prior to 1/1/2002	10 years of continuous employment
	1/1/2002 - 12/31/2006	15 years of regular full time continuous service
	1/1/2007 - 12/31/2013	20 years of regular full time continuous service
	Hired on or after 1/1/2014	Not eligible
	B. Protective	
Hired prior to 1/1/2002	15 years of continuous employment	
1/1/2002 - 12/31/2006	18 years of continuous service	
1/1/2007 - 12/31/2013	20 years of continuous service	
Hired on or after 1/1/2014	Not eligible	

* "Hire date" for part-time employees who became full time after January 1, 2014, is the date in which they were transferred or promoted to the regular full time position.
 "Hire date" for part-time employees who became full time on or before December 31, 2013 is based on their adjusted hire date.

Applicable to all: 1. Eligible retirees shall receive the same plan design as active employees, as modified from time to time.
 2. Refer to applicable collective bargaining agreement, Employee Handbook or Library manual for minimum age requirements for retiree medical benefit plan

ADDENDUM B

Medical Benefit Plan Coverage - Non-Duty Disability Pension; and LTDI

Group		Years of Service Required
Police Non-Sups (LPPNSA Local #26)	Hired prior to 7/1/2013	10 years of service as full time employee of the City Ends when retiree becomes eligible for Medicare Under LTDI the benefit ends when WRS terminates the employees LTDI benefit.
Police Supervisory (LPPNSA Local #91)	Hired prior to 7/1/2013	10 years of service as full time employee of the City Ends when retiree becomes eligible for Medicare Under LTDI the benefit ends when WRS terminates the employees LTDI benefit.
Fire (IAFF Local #127)	Hired prior to 7/1/2013	10 years of service as full time employee of the City Ends when retiree becomes eligible for Medicare Under LTDI the benefit ends when WRS terminates the employees LTDI benefit.
Transit (ATU Local #519) (Full time employees)	Hired prior to 1/1/2014	10 years of continuous employment with City Ends when retiree becomes eligible for Medicare Under LTDI the benefit ends when WRS terminates the employees LTDI benefit.
Non-Represented, SEIU (EE Handbook)*; and Library	Hired as regular full time prior to 1/1/2014	10 years of service as regular full time employee Ends when retiree becomes eligible for Medicare Under LTDI the benefit ends when WRS terminates the employees LTDI benefit.

* "Hire date" for part-time employees who became full time after January 1, 2014, is the date in which they were transferred or promoted to the regular full time position.

"Hire date" for part-time employees who became full time on or before December 31, 2013 is based on their adjusted hire date.

Applicable to all: 1. Eligible retirees shall receive the same plan design as active employees, as modified from time to time.

2. Refer to applicable collective bargaining agreement, Employee Handbook or Library manual for minimum age requirements for retiree medical benefit plan

ADDENDUM C

MEDICAL BENEFIT PLAN COVERAGE WHILE ON INCOME CONTINUATION INSURANCE

Full time employees who are participants in the City's medical benefit plan and are receiving the Income Continuation Insurance (ICI) benefit shall receive the same medical benefit plan benefits including contribution rates on the same basis as in effect for active employees, provided that they have a minimum of ten (10) years of continuous service as a full time employee for the City of La Crosse. This benefit ends when the employee becomes eligible for a Wisconsin Retirement System benefit of any kind (i.e. Normal Retirement pension, Duty Disability Retirement, Disability Retirement, or long Term Disability Insurance) or Medicare or Medicaid or for a period of one (1) year while on ICI, whichever occurs first.

Covered employees shall pay the same monthly contribution rates as are in effect for active employees as modified from time to time.

Eligible retirees shall receive the same plan design as active employees, as modified from time to time.

ADDENDUM D

RETIREE MEDICAL BENEFIT PLAN – DUTY DISABILITY

Full time employees who receive a duty disability pension shall receive the same benefits, including contributions, on the same basis as is in effect for active employees. This benefit ends when the retiree becomes eligible for Medicare. (For employees covered under the Employee Handbook, Library manual or ATU Local #519 collective bargaining agreement, this provision is only applicable to full time employee hired prior to January 1, 2014.)

Covered retirees shall receive the same plan design as active employees, as modified from time to time. Additionally they shall pay the same monthly rate contributions as in effect for active employees as modified from time to time.

Retirees, surviving spouse and dependents of retirees whose permanent residence is in an area not served by the Network will be considered as in-Network participants, however subject to Usual, Customary and Reasonable (UCR) fee limits. If the permanent residence is in the State of Wisconsin they must see in-network providers to be considered in-network participants.

ADDENDUM E

RETIREE MEDICAL BENEFIT PLAN – YOUNGER SPOUSE

When an eligible retiree (see addendum A) reaches Medicare age and his/her spouse is younger, the spouse may elect to continue his/her coverage in the City's medical benefit plan until the spouse reaches Medicare age provided that the spouse pays the total monthly pseudo premium rate. The eligible younger spouse of the retiree shall receive the same plan design as active employees.

Eligible retirees shall receive the same plan design as active employees, as modified from time to time.

Retirees, surviving spouse and dependents of retirees whose permanent residence is in an area not served by the Network will be considered as in-Network participants, however subject to Usual, Customary and Reasonable (UCR) fee limits. If the permanent residence is in the State of Wisconsin they must see in-network providers to be considered in-network participants.

ADDENDUM F

ONE PLAN FOR MARRIED EMPLOYEES

Married employees that both work for the City shall be limited to one medical benefit plan. Married employees that both work for the City would be allowed to switch “subscribers” during open enrollment if allowed to do so by state and federal law. In the event that the subscriber’s medical benefit plan is terminated, the remaining employee shall become the subscriber and the former subscriber shall become the dependent without any waiting periods.

ADDENDUM G

RETIREE MEDICAL BENEFIT PLAN – MEDICARE CARVE-OUT FOR DISABILITY

Make Whole:

Employees who retired on or before 12/31/2014, and who were participating in Medicare Part B as of 12/31/2014: The City shall make whole any retiree, spouse of current retiree, or surviving spouse for his/her Medicare Part B premium payments and waive the monthly retiree or surviving spouse benefit plan contribution. If a spouse of a current retiree meets this provision, the retiree’s monthly benefit plan contribution shall be waived.

Employees who retire after 12/31/2014: The retiree’s monthly out of pocket premium costs for the combined costs of Medicare Part B and City’s retiree medical benefit plan shall not exceed the cost of the City’s monthly retiree or surviving spouse monthly benefit plan contribution. If the cost of Medicare Part B is less than the cost of the City’s monthly retiree or surviving spouse benefit plan contribution, the retiree or surviving spouse shall only pay to the City the difference. If the cost of Medicare Part B is more than the cost of the City’s monthly retiree or surviving spouse benefit plan contribution, the City would provide the retiree/surviving spouse with an offset equal to the difference.

Eligible retiree, spouse of current retiree, or surviving spouse shall receive the same plan design as active employees, as modified from time to time.

ADDENDUM H

COVERAGE FOR SPOUSE & DEPENDENTS OF ELIGIBLE EMPLOYEES / RETIREES THAT DIE





Spouse and/or eligible dependents of an insured employee/retiree who dies before the employee/retiree becomes eligible for Medicare, shall be eligible to continue to participate in the City’s medical benefit plan if they have met the years of service requirement and date of hire provisions as defined in Addendum I.

Covered spouse and dependents of employees/retirees that die shall receive the same plan design as active employees, as modified from time to time. Additionally they shall pay the same monthly rate contributions as in effect for active employees as modified from time to time.

Surviving spouse and/or dependents of deceased employee/retiree whose permanent residence is in an area not served by the Network will be considered as in-Network participants, however subject to Usual, Customary and Reasonable (UCR) fee limits. If the permanent residence is in the State of Wisconsin they must see in-network providers to be considered in-network participants

ADDENDUM I

COVERAGE FOR SPOUSE AND DEPENDENTS OF ELIGIBLE EMPLOYEES/RETIREES THAT DIE
(Refer to Addendum H for specific coverage details)

Group	Hire date	Years of Service Required
Police Non-Sups (LPPNSA Local #26)	NA	NA
 Police Supervisory (LPPNSA Local #91)	NA	NA
 Fire (IAFF Local #127)	NA	NA
 Transit (ATU Local #519) (Full time employees)	Hired prior to 1/1/2014	8 years of full time consecutive service
 Non-Represented, SEIU (EE Handbook)*; and Library	Hired prior to 1/1/2012	Must have met eligibility requirements for retiree medical insurance as defined in Addendum A
	Hired on or after 1/1/2012	NA

ADDENDUM J

Health Care Cost Containment

The City will provide money for health care cost containment initiatives for bargaining unit members, and for employees covered under the Employee Handbook. The sum of money provided for these initiatives shall be based upon the number of regular full time members employed (within the applicable bargaining unit or Employee Handbook) as of January 1st of each respective year at a rate of \$50 per bargaining unit member/employee. Such funds are to be allocated as determined by the Health Care Cost Containment Committee. Committee expenses up to \$1,000 per year may be authorized by the Director of Human Resources. The funds for the health care cost containment shall be established for each individual unit, specifically LPPNSA, LPPSA, IAFF, ATU, and Employee Handbook.

City of La Crosse Schedule of Benefits

Effective 1/1/16

(Employees Represented by LPPNSA & LPPSA and Employees Covered Under the Employee Handbook & Library)

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	\$400 per Covered Person per year; not to exceed \$1,200 per Family Unit.	\$800 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 90%, following the deductible, EXCEPT as otherwise stated. The out of pocket maximum of co-insurance is \$600 per Covered Person not to exceed \$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).	Plan generally pays 70% following the deductible, EXCEPT as otherwise stated. No out of pocket maximum.
Maximum Out of Pocket (MOOP)	\$6,850 Individual / \$13,700 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 90% following the deductible for transportation to nearest local facility that provides the required treatment (<i>when medically necessary</i>).	Plan pays 90% of billed charges following the in-network deductible for transportation to nearest local facility that provides the required treatment (<i>when medically necessary</i>).
Autism	Plan pays 90% following the deductible when medically necessary for the conditions as outlined below.	Plan pays 70% 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 90% following \$20 co-pay per daily visit and/or exam and deductible (<i>Maintenance Services are excluded</i>).	Plan pays 90% of UCR charges following \$25 co-pay per daily visit and/or exam and deductible (<i>No Medical Necessity standard</i>). Limited to 18 out-of-network visits per calendar year.
Convenience Clinics	Plan pays 100%. Not subject to deductible.	Plan pays 80%. Not subject to deductible.

Covered Benefit	In Network	Out-of-network
Cochlear Implants (Children under age 18 who are profoundly hearing impaired)	Plan pays 90% following deductible. Prior authorization recommended.	Plan pays 70% 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.	
Dental Restorative Services - Basic (When Functionally Necessary) & Dental or Oral Surgery	Plan pays 90% following \$20 co-pay per visit or exam and deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following \$25 co-pay per visit or exam and deductible. Should service not be available in network, Plan will pay 90% 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 90% following \$20 co-pay per visit or exam and deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following \$25 co-pay per visit or exam and deductible. Should service not be available in network, Plan will pay 90% 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 90% following the deductible.	Plan pays 70% of UCR charges following the deductible. Lab services for emergency care are covered at 90% of billed charges following deductible for services originating from hospital outpatient emergency department until such discharge.
Durable Medical Equipment	Plan pays 90% following the deductible. Precertification notice recommended for rental or purchase.	Plan pays 70% of UCR charges following the deductible. Precertification notice recommended for rental or purchase.
Emergency room (includes facility and physician charges)	Plan pays 90% following \$75 co-pay and deductible. Copay is waived when admitted as an Inpatient within 24 hours.	Plan pays 90% 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 90% following the deductible when medically necessary according to the below time frames and age guidelines.	Plan pays 70% 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 90% following the deductible. Precertification notice recommended.	Plan pays 70% 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 90% 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.	Plan pays 70% of UCR charges following the deductible. Precertification notice recommended.
Hospital-Inpatient (Room & Board)	Plan pays 90% following the deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following the deductible. Services for emergency care are covered at 90% 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 90% following the deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following the deductible. Services for emergency care are covered at 90% 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 90% following the deductible. If a physician charges a separate fee for the inpatient office visit, Plan pays 90% following \$20 co-pay per visit or exam and deductible. <i>(Maintenance services excluded)</i> Precertification notice recommended.	Plan pays 70% of UCR charges following the deductible. If a physician charges a separate fee for the inpatient office visit, Plan pays 70% of UCR charges following \$25 co-pay per visit or exam and deductible. Services for emergency care are covered at 90% of billed charges after the in-network deductible for facility services continuous from the hospital outpatient emergency department through any immediately succeeding inpatient stay. <i>(Maintenance services excluded)</i> Precertification notice recommended.
Mental health and substance abuse - Outpatient (including urgent care)	Plan pays 90% following \$20 co-pay per visit or exam and deductible. <i>For outpatient mental health and substance abuse care in an outpatient hospital setting, refer to the outpatient hospital benefit.</i> <i>(Maintenance services excluded)</i> Precertification notice recommended.	Plan pays 70% of UCR charges following \$25 co-pay per visit or exam and deductible. <i>For outpatient mental health and substance abuse care in an outpatient hospital setting, refer to the outpatient hospital benefit.</i> <i>(Maintenance services excluded)</i> 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). Includes but is not limited to: <ul style="list-style-type: none"> • 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)	Plan pays 70% of UCR charges following \$25 co-pay and deductible.
Physician	Plan pays 90% following \$20 co-pay per visit or exam and deductible. Applies to in-network Urgent Care visits within the state of WI	Plan pays 70% 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 90% 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 90% 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 90% following the deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following the deductible. Precertification notice recommended.
Surgeon	Plan pays 90% following \$20 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).	Plan pays 70% of UCR charges following \$25 co-pay per visit or exam (when a separate exam or visit fee is billed) and deductible.
Therapy Services for Disability (Non-Physician) Physical, occupational & speech therapies, radiation, chemotherapy, dialysis treatments, respiratory, Cardiac rehabilitation phases I & II	Plan pays 90% following deductible. <i>(Maintenance Services are excluded)</i> Precertification notice recommended.	Plan pays 70% of UCR charges following deductible. <i>(Maintenance Services are excluded)</i> Precertification notice recommended.
Vision Exam - Routine	Following a \$10 co-pay per visit or exam and deductible, the Plan pays 90% up to an \$80 maximum benefit combined per Covered Person per Calendar Year for in network and out of network (by physician or optometrist). The \$80 limit does not apply for vision exams for children under age 19.	Following a \$10 co-pay per visit or exam and in network deductible , the Plan pays 70% of UCR charges up to an \$80 maximum benefit combined per Covered Person per Calendar Year for in network and out of network (by physician or optometrist). The \$80 limit does not apply for vision exams for children under age 19.

COVERED RETIRED EMPLOYEES with a permanent residence outside of the state of Wisconsin will have coverage for out-of-NETWORK providers generally covered at 90% 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	\$25 for up to 30 day supply
Speciality medication per formulary prescription (obtained through a Specialty Pharmacy)	\$50 for up to a 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 \$50 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	\$50 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 \$100 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 \$6,850 Individual / \$13,700 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)

City of La Crosse Schedule of Benefits

Effective 1/1/16 - IAFF Local #127 Employees Hired on/after 7/1/11 & Pre-1/6/12 IAFF Retirees

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	\$400 per Covered Person per year; not to exceed \$1,200 per Family Unit.	\$800 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 90%, following the deductible, EXCEPT as otherwise stated. The out of pocket maximum of co-insurance is \$600 per Covered Person not to exceed \$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).	Plan generally pays 70%, following the deductible, EXCEPT as otherwise stated. No out of pocket maximum.
Maximum Out of Pocket (MOOP)	\$6,850 Individual / \$13,700 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 90% following the deductible for transportation to nearest local facility that provides the required treatment (<i>when medically necessary</i>).	Plan pays 90% of billed charges following the in network deductible for transportation to nearest local facility that provides the required treatment (<i>when medically necessary</i>).
Autism	Plan pays 90% following the deductible when medically necessary for the conditions as outlined below.	Plan pays 70% 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 90% following \$20 co-pay per daily visit and/or exam and deductible (<i>Maintenance Services are excluded</i>).	Plan pays 70% of UCR charges following \$25 co-pay per daily visit and/or exam and deductible (<i>No Medical Necessity standard</i>). Limited to 18 out-of-network visits per calendar year.
Convenience Clinics	Plan pays 100%. Not subject to deductible.	Plan pays 80%. Not subject to deductible.
Cochlear Implants (Children under age 18 who are profoundly hearing impaired)	Plan pays 90% following deductible. Prior authorization recommended.	Plan pays 70% of UCR charges following 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 90% following \$20 co-pay per visit or exam and deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following \$25 co-pay per visit or and deductible. Should service not be available in network, Plan will pay 90% of UCR charges following \$20 co-pay per visit or exam and 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 90% following \$20 co-pay per visit or exam and deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following \$25 co-pay per visit or exam and deductible. Should service not be available in network, Plan will pay 90% of UCR charges following \$20 co-pay per visit or exam and 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 90% following the deductible.	Plan pays 70% of UCR charges following the deductible.
Durable Medical Equipment	Plan pays 90% following the deductible. Precertification notice recommended for rental or purchase.	Plan pays 70% of UCR charges following the deductible. Precertification notice recommended for rental or purchase.
Emergency room (includes facility and physician charges)	Plan pays 90% following \$75 co-pay and the deductible. Co-pay is waived when admitted as an Inpatient within 24 hours.	Plan pays 90% of billed charges following \$75 co-pay and the in network deductible. Co-pay is waived when admitted as an Inpatient within 24 hours.
Hearing Aids (Children under age 18)	Plan pays 90% following the deductible when medically necessary according to the below time frames and age guidelines.	Plan pays 70% 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 90% following the deductible. Precertification notice recommended.	Plan pays 70% 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 90% following the deductible Precertification notice recommended	Plan pays 70% 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 90% following the deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following the deductible. Services for emergency care are covered at 90% 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 90% following the deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following the deductible. Services for emergency care are covered at 90% 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 90% following the deductible. If a physician charges a separate fee for the inpatient office visit, Plan pays 90% following \$20 co-pay per visit or exam and the deductible. <i>(Maintenance services excluded)</i> Precertification notice recommended.	Plan pays 70% of UCR charges following the deductible. If a physician charges a separate fee for the inpatient office visit, Plan pays 70% of UCR charges following \$25 co-pay per visit or exam and the deductible. Services for emergency care are covered at 90% of billed charges after the in network deductible for facility services continuous from the hospital outpatient emergency department through any immediately succeeding inpatient stay. <i>(Maintenance services excluded)</i> Precertification notice recommended.
Mental health and substance abuse - Outpatient (including urgent care)	Plan pays 90% following \$20 co-pay per visit or exam and deductible. <i>For outpatient mental health and substance abuse care in an outpatient hospital setting, refer to the outpatient hospital benefit.</i> <i>(Maintenance services excluded)</i> Precertification notice recommended.	Plan pays 70% of UCR charges following \$25 co-pay per visit or exam and deductible. <i>For outpatient mental health and substance abuse care in an outpatient hospital setting, refer to the outpatient hospital benefit.</i> <i>(Maintenance services excluded)</i> Precertification notice recommended.

Covered Benefit	In Network	Out-of-network
Preventive Services as defined under the Patient Protection and Affordable Care Act (PPACA also known as Affordable Care Act)	Plan pays 100% (no co-pay or deductible). Includes but is not limited to: <ul style="list-style-type: none"> • 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 ACA" handout for details or contact Plan Supervisor)	Plan pays 70% of UCR charges following \$25 co-pay and deductible.
Physician	Plan pays 90% following \$20 co-pay per visit or exam and deductible. Applies to in-network Urgent Care visits within the state of WI	Plan pays 70% 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 90% 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 90% of billed amount for services originating after the hospital outpatient emergency department through any immediately succeeding inpatient stay.
Skilled Nursing Facility	Plan pays 90% following the deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following the deductible. Precertification notice recommended.
Surgeon	Plan pays 90% following \$20 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 including diagnostic screenings, pathologists, radiologists, anesthesiologists, non-physician rehabilitation therapy and non-physician allergy services.	Plan pays 70% of UCR charges following \$25 co-pay per visit or exam (when a separate exam or visit fee is billed) and deductible (Limited to 18 service visits per year for Out-of-Network). 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 therapies, radiation, chemotherapy, dialysis treatments, respiratory, Cardiac rehabilitation phases I & II	Plan pays 90% following deductible. <i>(Maintenance Services are excluded)</i> Precertification notice recommended.	Plan pays 70% of UCR charges following deductible. <i>(Maintenance Services are excluded)</i> Precertification notice recommended.
Vision Exam - Routine	Following a \$10 co-pay per visit or exam and deductible, the Plan pays 90% up to an \$80 maximum benefit combined per Covered Person per Calendar Year for in network and out of network (by physician or optometrist). The \$80 limit does not apply for vision exam for children under age 19.	Following a \$10 co-pay per visit or exam and in network deductible, the Plan pays 70% of UCR charges up to an \$80 maximum benefit combined per Covered Person per Calendar Year for in network and out of network (by physician or optometrist). The \$80 limit does not apply for vision exams for children under age 19.

COVERED RETIRED EMPLOYEES with a permanent residence outside of the state of Wisconsin will have coverage for out-of-NETWORK providers generally covered at 90% 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	\$25 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 \$50 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	\$50 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 \$100 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 \$6,850 Individual / \$13,700 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)

City of La Crosse Schedule of Benefits

Effective 1/1/16 - IAFF Local #127 Active Pre-7/1/11 Hires & Post 1/6/12 Retirees

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	\$2,500 per Covered Person; not to exceed \$7,500 per Family Unit.	
	<p>Deductibles for in network and Out-of-network cross apply.</p> <p>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.</p>	
Co-insurance after deductible is met (Any Co-pay is additional)	Plan generally pays 90%, following the deductible, EXCEPT as otherwise stated. The out of pocket maximum of co-insurance is \$600 per Covered Person not to exceed \$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).	Plan generally pays 70%, following the deductible, EXCEPT as otherwise stated. No out of pocket maximum.
Maximum Out of Pocket (MOOP)	\$6,850 Individual / \$13700 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 90% following the deductible for transportation to nearest local facility that provides the required treatment (<i>when medically necessary</i>).	Plan pays 90% of billed charges following the deductible for transportation to nearest local facility that provides the required treatment (<i>when medically necessary</i>).
Autism	Plan pays 90% following the deductible when medically necessary for the conditions as outlined below.	Plan pays 70% 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 90% following \$20 co-pay per daily visit and/or exam and deductible (<i>Maintenance Services are excluded</i>).	Plan pays 70% of UCR charges following \$25 co-pay per daily visit and/or exam and deductible (<i>No Medical Necessity standard</i>). Limited to 18 out-of-network visits per calendar year.
Convenience Clinics	Plan pays 100%. Not subject to deductible.	Plan pays 80%. Not subject to deductible.
Cochlear Implants (Children under age 18 who are profoundly hearing impaired)	Plan pays 90% following deductible. Prior authorization recommended.	Plan pays 70% of UCR charges following 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.	
Dental Restorative Services - Basic (When Functionally Necessary) & Dental or Oral Surgery	Plan pays 90% following \$20 co-pay per visit or exam and deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following \$25 co-pay per visit or exam and deductible. Should service not be available in network, Plan will pay 90% of UCR charges following \$20 co-pay per visit or exam and 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 90% following \$20 co-pay per visit or exam and deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following \$25 co-pay per visit or exam and deductible. Should service not be available in network, Plan will pay 90% of UCR charges following \$20 co-pay per visit or exam and 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 90% following the deductible.	Plan pays 70% of UCR charges following the deductible.
Durable Medical Equipment	Plan pays 90% following the deductible. Precertification notice recommended for rental or purchase.	Plan pays 70% of UCR charges following the deductible. Precertification notice recommended for rental or purchase.
Emergency room (includes facility and physician charges)	Plan pays 90% following \$75 co-pay and the deductible. Co-pay is waived when admitted as an Inpatient within 24 hours.	Plan pays 90% of billed charges following \$75 co-pay and the deductible. Co-pay is waived when admitted as an Inpatient within 24 hours.
Hearing Aids (Children under age 18)	Plan pays 90% following the deductible when medically necessary according to the below time frames and age guidelines.	Plan pays 70% 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 90% following the deductible. Precertification notice recommended.	Plan pays 70% 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 90% following the deductible Precertification notice recommended	Plan pays 70% 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 90% following the deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following the deductible. Services for emergency care are covered at 90% of billed charges after the 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 90% following the deductible. Precertification notice recommended.	Plan pays 70% of UCR charges following the deductible. Services for emergency care are covered at 90% of billed charges after the deductible for services originating from Hospital Outpatient emergency department until discharge. Precertification notice recommended.
Mental health and substance abuse - Inpatient	Plan pays 90% following the deductible. If a physician charges a separate fee for the inpatient office visit, Plan pays 90% following \$20 co-pay per visit or exam and the deductible. <i>(Maintenance services excluded)</i> Precertification notice recommended.	Plan pays 70% of UCR charges following the deductible. If a physician charges a separate fee for the inpatient office visit, Plan pays 70% of UCR charges following \$25 co-pay per visit or exam and the deductible. Services for emergency care are covered at 90% of billed charges after the deductible for facility services continuous from the hospital outpatient emergency department through any immediately succeeding inpatient stay. <i>(Maintenance services excluded)</i> Precertification notice recommended.
Mental health and substance abuse - Outpatient (including urgent care)	Plan pays 90% following \$20 co-pay per visit or exam and deductible. <i>For outpatient mental health and substance abuse care in an outpatient hospital setting, refer to the outpatient hospital benefit.</i> <i>(Maintenance services excluded)</i> Precertification notice recommended.	Plan pays 70% of UCR charges following \$25 co-pay per visit or exam and deductible. <i>For outpatient mental health and substance abuse care in an outpatient hospital setting, refer to the outpatient hospital benefit.</i> <i>(Maintenance services excluded)</i> Precertification notice recommended.

Covered Benefit	In Network	Out-of-network
Preventive Services as defined under the Patient Protection and Affordable Care Act (PPACA also known as the Affordable Care Act)	Plan pays 100% (no co-pay or deductible).	Plan pays 70% of UCR charges following \$25 co-pay and deductible.
	Includes but is not limited to: <ul style="list-style-type: none"> • 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 ACA" handout for details or contact Plan Supervisor)	
Physician	Plan pays 90% following \$20 co-pay per visit or exam and deductible. Applies to in-network Urgent Care visits within the state of WI	Plan pays 70% 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 90% following a \$75 co-pay per visit or exam and deductible. For Emergency In-Patient services, after a \$20 co-pay per visit or exam and deductible the Plan pays 90% 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 90% following the deductible. Precertification notice recommended.	Plan pays 70% 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.	
Surgeon	Plan pays 90% following \$20 co-pay per visit or exam (when a separate exam or visit fee is billed) and deductible.	Plan pays 70% of UCR charges following \$25 co-pay per visit or exam (when a separate exam or visit fee is billed) and deductible (Limited to 18 service visits per year for Out-of-Network).
	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 therapies, radiation, chemotherapy, dialysis treatments, respiratory, Cardiac rehabilitation phases I & II	Plan pays 90% following deductible. (Maintenance Services are excluded) Precertification notice recommended.	Plan pays 70% of UCR charges following deductible. (Maintenance Services are excluded) Precertification notice recommended.
Vision Exam - Routine	Following a \$10 co-pay per visit or exam and deductible, the Plan pays 90% up to an \$80 maximum benefit combined per Covered Person per Calendar Year for in network and out of network (by physician or optometrist). The \$80 limit does not apply for vision exam for children under age 19.	Following a \$10 co-pay per visit or exam and deductible, the Plan pays 70% of UCR charges up to an \$80 maximum benefit combined per Covered Person per Calendar Year for in network and out of network (by physician or optometrist). The \$80 limit does not apply for vision exams for children under age 19.

COVERED RETIRED EMPLOYEES with a permanent residence outside of the state of Wisconsin will have coverage for out-of-NETWORK providers generally covered at 90% 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	\$25 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 \$50 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	\$50 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 \$100 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 \$6,850 Individual / \$13,700 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)

(Schedule of Benefits Revised 10/2015)