MEDICAL PLAN SUMMARY - TRADITIONAL PLAN ($2500)

Applicable to Employees Represented Under IAFF Hired before 7/1/11 & Post 1/6/12 IAFF Retirees

To follow is a *brief* summary of current 2026 benefit. *Please refer to the Schedule of Benefits and/or Master Plan Document/Summary Plan Description for complete details* www.cityoflacrosse.org/hr/eebenefits.

2026 Monthly Contribution Amount

Plan Type	Monthly Rate if did 2025 Health Risk Assessment (12.6% of plan cost)	Monthly Rate if did not do 2025 Health Risk Assessment (16% of plan cost)
Single	$101.32	$128.66
Limited Family (2 person)	$209.54	$266.08
Family	$255.08	$323.90

Provision	Coverage
Annual deductible	$2,500 per Person/maximum of $7,500 per Family Unit. *(Deductible for in and out of network cross apply)*
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 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 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 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	At no cost to member (no deductible, co-pay or co-insurance)
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) **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.