

# MEDICAL PLAN SUMMARY - **HIGH DEDUCTIBLE HEALTH PLAN**

Available 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 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](http://www.cityoflacrosse.org/hr/eebenefits).

## 2026 Monthly Contribution Amount

Plan Type	Monthly Rate if did 2025 Health Risk Assessment (5% of plan cost)	Monthly Rate if did not do 2025 Health Risk Assessment (16% of plan cost)
Single	\$37.00	\$118.44
Limited Family (2 person)	\$76.54	\$244.96
Family	\$93.18	\$298.22

Provision	Coverage																
<b>Annual deductible</b>  <i>*With exception of preventive services, all medical claim &amp; Rx drug costs will go to your deductible</i>	<b>In-Network:</b> \$3,500 per Person / maximum of \$7,000 per Family Unit. <b>Out-of-Network:</b> \$7,000 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.																
<b>Co-insurance after deductible is met</b>	<b>In-Network:</b> Plan pays 100% <b>Out-of-Network:</b> Plan generally pays 70% & Member pays 30% of UCR charges																
<b>Maximum Out of Pocket (MOOP)</b>	<b>In-Network:</b> \$7,000 per Person / \$14,000 per Family Unit. <b>Out-of-Network:</b> \$14,000 per Person / \$28,000 per Family Unit.																
<b>Co-Pays</b>	<table style="width: 100%; border: none;"> <thead> <tr> <th style="border: none;">In-Network</th> <th style="border: none;">Out-of-Network</th> </tr> </thead> <tbody> <tr> <td style="border: none;"><b>Office Visit Co-pay</b></td> <td style="border: none;">\$20 per visit or exam</td> </tr> <tr> <td style="border: none;"><b>ER Co-pay</b></td> <td style="border: none;">\$75 (waived if admitted within 24 hours)</td> </tr> <tr> <td style="border: none;"><b>Chiropractic Co-pay</b></td> <td style="border: none;">\$20 per daily visit or exam</td> </tr> <tr> <td style="border: none;"><b>Inpatient Co-pay</b></td> <td style="border: none;">\$150 per admission</td> </tr> <tr> <td style="border: none;"><b>Outpatient Co-pay</b></td> <td style="border: none;">\$150 per occurrence</td> </tr> <tr> <td style="border: none;"><b>Convenience Clinic (Express Care)</b></td> <td style="border: none;">No copay if deductible met</td> </tr> <tr> <td style="border: none;"><b>Anthem's LiveHealth On-line</b></td> <td style="border: none;">No cost – Plan pays 100%</td> </tr> </tbody> </table>	In-Network	Out-of-Network	<b>Office Visit Co-pay</b>	\$20 per visit or exam	<b>ER Co-pay</b>	\$75 (waived if admitted within 24 hours)	<b>Chiropractic Co-pay</b>	\$20 per daily visit or exam	<b>Inpatient Co-pay</b>	\$150 per admission	<b>Outpatient Co-pay</b>	\$150 per occurrence	<b>Convenience Clinic (Express Care)</b>	No copay if deductible met	<b>Anthem's LiveHealth On-line</b>	No cost – Plan pays 100%
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<b>Neighborhood Family Clinic</b>	\$20 per visit - Must be paid by member to NFC at time of service <i>Co-pay &amp; claim do not apply to Deductible</i>																
<b>Preventive Services as defined under the Patient Protection and Affordable Care Act (ACA)</b>	<b>In-Network:</b> Plan pays 100% <b>Out-of-Network:</b> \$40 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)																
<b>Rx Drug Co-pays</b>  <b>Apply AFTER deductible is met</b>  <b>*Using ServeYou Rx Select Formulary found at <a href="http://www.ServeYouRx.com">www.ServeYouRx.com</a></b>	Copays below apply <b>AFTER</b> the deductible is met: Generic Tier 1: \$0 Brand Tier 2: \$20 retail (30 day) / \$40 mail order (90 day) \$60 (90 day at retail) Tier 3: \$50 retail (30 day) / \$100 mail order (90 day) \$150 (90 day at retail) <i>*90 day mail order (2 copays) OR 90 day at retail (3 copays) required for Maintenance Drugs after first two 30 day retail fills.</i>																

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

**Note: The plan would apply cost sharing in the following order.**

- 1) **Co-pay** if applicable to such service.
- 2) **Deductible** – All medical & Rx drug claims will go towards deductible until the individual or family max is met.
- 3) **Co-insurance** – Not applicable in-network. Applies to out-of-network claims unless individual or family max is met)