The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.

For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.CityofLaCrosse.org/MedicalPlanMPD or call City Human Resources at 608-789-7595. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.CityofLaCrosse.org/HR/EEBenefits or call 608-789-7595 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In Network: $275Individual / $825 maximum per Family Out of Network: $600 Individual/no Family maximum	Generally, you must pay all the costs up to the individual deductible amount or family maximum deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes, Preventive care & covered services at the NFC, SmartChoiceMRI & Convenience Clinics.	For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductible for specific services.
What is the out-of-pocket limit for this plan?	Yes. Total plan out-of-pocket limit $8150 Individual/$16300 Family in network.	Once the in-network deductible limit is reached, the plan pays 100% of eligible services, however, copayments and fixed dollar limits or visits limits, when applicable, would still pertain. The total plan out-of-pocket limit is the most you could pay per year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, out of network payments, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. Visit www.Anthem.com or call 1-833-578-4439 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

On this chart, all **copayments** are applied before your **deductible** & **coinsurance** costs applied after your **deductible** has been met, if a **deductible** or **coinsurance** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment/visit	$25 copayment/visit & 20% coinsurance	Copayment waived for pathologists, radiologists, anesthesiologist, non-physician rehabilitation therapy and non-physician allergy services.
	Specialist visit			
	Preventive care/screening/ immunization	No charge.	$25 copayment/visit & 20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge.	20% coinsurance	----------None----------
	Imaging (CT/PET scans, MRIs)			Services at SmartChoiceMRI No Cost
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.serve-you-rx.com or call Serve You Rx at 1-800-759-3203	Formulary Tier 1 Generic drugs	$10 copay 30 day/retail $20 copay 90 day at mail order	Excluded*	90 Day mail order required after first two 30 day retail fills for Maintenance Medications. *Out-of-network prescription drugs generally not covered.
	Formulary Tier 2 Brand drugs	$20 copay 30 day/retail $40 copay 90 day At mail order	Excluded*	
	Non Formulary Tier 3 drugs	100%	100%	Serve You Rx may approve an exception if member has tried formulary drugs without success or if there is a medical reason why member cannot take formulary drug(s).
	Formulary Specialty drugs	$20 copayment/ prescription	Excluded *	Limited to 30 day supply and must be obtained from Serve You Rx Specialty Pharmacy. Preauthorization may be required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge.	20% coinsurance	----------None----------
	Physician/surgeon fees	$20 copayment/visit	$25 copayment/visit	Copayment applies only if physician visit is billed.

If you need immediate medical attention	Emergency room care	$75 copayment/visit	$75 copayment/visit, in network deductible	Copayment waived if admitted to inpatient status within 24 hours.
	Emergency medical transportation	No charge.	in network deductible	Out of network paid off billed charges.
	Urgent care	$20 copayment/visit	$25 copayment/visit & 20% coinsurance	Out of state: $75 copayment, in network co-insurance & deductible
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge.	20% coinsurance	----------None----------
	Physician/surgeon fees	$20 copayment/visit	$25 copayment/visit & 20% coinsurance	Copayment applies only if physician visit is billed.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copayment/visit	$25 copayment/visit & 20% coinsurance	Maintenance services excluded.
	Inpatient services			
If you are pregnant	Office visits	$20 copayment/visit	$25 copayment/visit & 30% coinsurance	Copayment only applies when a physician visit is billed.
	Childbirth/delivery professional services	$20 copayment/visit	$25 copayment/visit & 20% coinsurance	Copayment applies only if a physician visit is billed.
	Childbirth/delivery facility services	No charge.	20% coinsurance	----------None----------
If you need help recovering or have other special health needs	Home health care	No charge.	20% coinsurance	Limited to 40 visits per year.
	Rehabilitation services			Maintenance services excluded. Pre-authorization is recommended.
	Habilitation services			
	Skilled nursing care			Limited to 60 days per year.
	Durable medical equipment			Preauthorization is recommended for purchases and rentals.
	Hospice services			Limited to 180 daily visits per lifetime.
If your child needs dental or eye care	Children's eye exam	$10 copayment/visit	$10 copayment/visit & in network deductible & 20% Coinsurance	Limited to one routine eye exam per year.
	Children's glasses	Excluded	Excluded	Excluded
	Children's dental check-up	Excluded	Excluded	Excluded

Excluded Services & Other Covered Services:

Services Your Generally Does NOT Cover (Check your policy or Plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Hearing aids (except for children under 18)
- Infertility Treatment
- Long Term Care
- Non-Emergency care when traveling outside the USA
- Private Duty Nursing
- Routine Dental Care or Orthodontics
- Routine Foot Care
- Over the Counter Orthotics
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Adult Eye Exam
- Bariatric Surgery
- Chiropractic Care
- Dental Restorative Services & Specific Oral Surgeries (defined in MPD
- Emergency coverage provided outside the USA
- Hearing Aids for children under 18
- Hearing Exam

Your Rights to Continue Coverage: If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact City of La Crosse Employee Benefits Coordinator at (608) 789-8310. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact your plan administrator Anthem Blue Cross Blue Shield at 1-833-578-4439.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	$275
■ Specialist copayments	$20

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$275
Copayments (Office Visit & Rx Drug)	$73
Coinsurance	$0
What isn't covered	
Limits or exclusions	$11
The total Peg would pay is	**$359**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	$275
■ Specialist copayments	$20

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$275
Copayments (Office Visit & Rx Drug)	$720
Coinsurance	$0
What isn't covered	
Limits or exclusions	$33.93
The total Joe would pay is	**$1028.93**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ The plan's overall deductible	$275
■ Specialist copayments	$20

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$275
Copayments (Office Visit & ER)	$115
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$390**

The plan would be responsible for the other costs of these EXAMPLE covered services.