



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.mygisc.com](http://www.mygisc.com) or by calling 1-800-242-4472.

Important Questions	Answers	Why this Matters:
<p><b>What is the overall <u>deductible</u>?</b></p>	<p><b>Preferred Providers</b> \$200 Person/\$400 per Family</p> <p><b>NonPreferred Providers</b> \$500 Person/ \$1000 per Family .</p> <p>Doesn't apply to preventive &amp; prescriptions. Copayments &amp; Coinsurance do not count toward deductible. Deductibles for Preferred/NonPreferred are separate.</p>	<p>You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. See the Common Medical Event chart for how much you pay for covered services after you meet the <u>deductible</u>.</p> <p>Your plan year: January 1, 2015 through December 31, 2015.</p>
<p><b>Are there other <u>deductibles</u> for specific services?</b></p>	<p>No</p>	<p>You don't have to meet <b>deductibles</b> for specific services, but see the Common Medical Event chart for other costs for services this plan covers.</p>
<p><b>Is there an <u>out-of-pocket limit</u> on my expenses?</b></p>	<p>Yes.</p> <p><b>Preferred Providers</b> \$600 Person/\$1200 per Family includes deductible &amp; coinsurance Maximum out of pocket to include deductible, coinsurance &amp; copayments is \$5,350 Individual Coverage &amp; \$11,000 Two-Person/Family Coverage</p> <p><b>NonPreferred Providers</b> \$1500 Person/\$2000 per Family. Out of pocket limits for Preferred &amp; NonPreferred are separate.</p> <p><b>Prescription Drug</b> Out of pocket \$1250 Person &amp; \$2500 Family.</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</p>

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# Employee Group Health Plan: City of Burlington

Coverage Period: 01/01/15-06/30/15

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Employee/Dependent | Plan Type: PPO

<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p>Premiums, balance billed charges, penalties and health care this plan doesn't cover. Copayments apply to your <b>Preferred Maximum &amp; Prescription Drug</b> out of pocket.</p>	<p>Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b>.</p>
<p>Is there an overall annual limit on what the plan pays?</p>	<p>No.</p>	<p>This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The Common Medical Event chart describes <i>specific</i> coverage limits, such as limits on the number of office visits.</p>
<p>Does this plan use a <u>network of providers</u>?</p>	<p>Yes, for a list of <b>preferred providers</b>, see <a href="http://www.cigna.com">www.cigna.com</a> or call 1-800-242-4472</p>	<p>If you use a preferred doctor or other health care <b>provider</b>, this plan will pay some or all of the costs of covered services. Be aware, your preferred doctor or hospital may use a non-preferred <b>provider</b> for some services. Plans use the term in-net-work, <b>preferred</b>, or participating for <b>providers</b> in their network. See the Common Medical Event chart for how this plan pays different kinds of <b>providers</b>.</p>
<p>Do I need a referral to see a <u>specialist</u>?</p>	<p>No</p>	<p>You can see the <b>specialist</b> you choose without permission from this plan.</p>
<p>Are there services this plan doesn't cover?</p>	<p>Yes</p>	<p>Some of the services this plan doesn't cover are listed in the Excluded Services &amp; Other Covered Services. See your policy or plan document for additional information about <b>excluded services</b>.</p>

- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

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Common Medical Event	Services You May Need	Your Cost If You Use an Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	\$10 copay/visit	Deductible then 30% coinsurance	None
	Specialist visit	\$10 copay/visit	Deductible then 30% coinsurance	Mental Health, Alcohol & Drug Rehab office visits are not covered with a non-preferred provider
	Other practitioner office visit	\$10 copay/visit	Deductible then 30% coinsurance	Includes Chiropractor, Nutritionist. No coverage with nonpreferred provider for Chiropractor/ Nutritionist
	Preventive care/screening/immunization	No charge	Deductible then 30% coinsurance	Preventive care benefits must meet the plan's definition of screening/preventive.
	Screening mammogram	No charge	No charge	See also, "if you have a test" for diagnostic tests or imaging
	Colorectal screening	No charge	Deductible then 30% coinsurance	See also, "if you have a test" for diagnostic tests or imaging
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	Office based: Deductible then 20% coinsurance. Outpatient Hospital: Deductible then 20% coinsurance	Office based: Deductible then 30% coinsurance. Outpatient Hospital: Deductible then 30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	Deductible then 20% coinsurance	Deductible then 30% coinsurance	None

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<p><b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://www.maxorplus.com">www.maxorplus.com</a></p>	Generic drugs	Retail: \$10 copay per 30 day supply; Mail Order: \$20 copay per 90 day supply prescription retail	Not covered	Some drugs require prior authorization to be covered.  Split Incentive program available through mail order at no charge.
	Preferred & Non-preferred brand drugs	Retail: \$15 copay per 30 day supply; Mail Order: \$30 copay per 90 day supply prescription retail	Not covered	Prescription drug out-of-pocket limit: \$1,250 person/\$2,500 family.
	Contraception, Diabetic Drugs & Supplies & Smoking Cessation	No charge	Not covered	Covers most diabetic medication & supplies. Smoking Cessation products include prescription & over the counter drugs with prescription.
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	Deductible then 20% coinsurance	Deductible then 30% coinsurance	Some services may require prior approval
	Physician/surgeon fees	Deductible then 20% coinsurance	Deductible then 30% coinsurance	None
<p><b>If you need immediate medical attention</b></p>	Emergency room services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	Services for medical emergency only
	Emergency medical transportation	Deductible then 20% coinsurance	Deductible then 20% coinsurance	Services for medical emergency only. Approval within 48 hours is required for emergency air or water transportation.
	Urgent care	\$10 copay/visit	\$10 copay/visit	None
<p><b>If you have a hospital stay</b></p>	Facility fee (e.g., hospital room)	Deductible then 20% coinsurance	Deductible then 30% coinsurance	Preauthorization required.
	Physician/surgeon fee	Deductible then 20% coinsurance	Deductible then 30% coinsurance	Preauthorization required.

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<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	Deductible then 20% coinsurance	100%	No coverage with Non-Preferred Providers.
	Mental/Behavioral health inpatient services	Deductible then 20% coinsurance	100%	Preauthorization required for Preferred Providers. No coverage with Non-Preferred Providers.
	Substance use disorder outpatient services	Deductible then 20% coinsurance	100%	No coverage with Non-Preferred Providers.
	Substance use disorder inpatient services	Deductible then 20% coinsurance	100%	Preauthorization required for Preferred Providers. No coverage with Non-Preferred Providers.
<b>If you are pregnant</b>	Prenatal and postnatal care	Deductible then 20% coinsurance	Deductible then 30% coinsurance	None
	Delivery and all inpatient services	Deductible then 20% coinsurance	Deductible then 30% coinsurance	Preauthorization required for stay more than 48 hours normal delivery or 96 hours C-Section
<b>If you need help recovering or have other special health needs</b>	Home health care	Deductible then 20% coinsurance	Deductible then 30% coinsurance	Prior approval is required.
	Rehabilitation services	Inpatient: Deductible then 20% coinsurance  Outpatient: Deductible then 20% coinsurance	Inpatient & Outpatient: 100%	Inpatient: preauthorization required, precertification is required every 30 days. Physical, Occupational & Speech therapy 30 visit maximum per calendar year. Cardiac Rehab up to 36 visits. No coverage with Non-Preferred Providers.

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If you need help recovering or have other special health needs	Habilitation services	Varies based on type or place of service. See applicable row in this table.	Varies based on type or place of service. See applicable row in this table.	Inpatient: preauthorization required, precertification is required every 30 days. Physical, Occupational & Speech therapy 30 visit maximum per calendar year. ABA therapy-see Mental/Behavioral Health office visits.
	Skilled nursing care	Deductible then 20% coinsurance	100%	Preauthorization required. No coverage with Non-Preferred Providers.
	Durable medical equipment	Deductible then 20% coinsurance	Deductible then 30% coinsurance	None
	Hospice service	Deductible then 20% coinsurance	Deductible then 30% coinsurance	Preauthorization required.
If you or your child needs dental or eye care	Eye exam	Adults & Children: \$10 copay per exam	Adults & Children: \$10 copay per exam	1 exam per calendar year. Excludes other supplemental tests & evaluation/fitting of contact lenses
	Glasses	Not Covered	Not Covered	Coverage through Vision Plan
	Dental check up	Not Covered	Not Covered	Coverage through Dental Plan

## Excluded Services & Other Covered Services:

### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (adults & children)
- Hearing Aids,
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care except for treatment for diabetics
- Weight loss programs.

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## Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care – approval after 12 visits is required
- Infertility treatment
- Private Duty nursing
- Routine Eye Care (adults & children)

## Your Rights to Continue Coverage:

If you lose covered 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 the plan at 1-800-242-4472. 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](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the plan at 1-800-242-4472. 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](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

**Language Access Services:** Spanish (Español): Para obtener asistencia en Español, llame al 1-800-242-4472

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

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$6,990
- Patient pays \$ 550

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$200
Copays	\$0
Coinsurance	\$200
Limits or exclusions	\$150
<b>Total</b>	<b>\$550</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,920
- Patient pays \$480

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$200
Copays	\$100
Coinsurance	\$100
Limits or exclusions	\$80
<b>Total</b>	<b>\$480</b>

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

✘ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

✘ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.