



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 or by calling 1-800-242-4472.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	Preferred \$200 Person/\$400 per Family; Non-Preferred \$500 Person/\$1000 per Family. Doesn't apply to preventive & prescriptions. Copayment & Coinsurance do not count toward deductible. Deductibles for Preferred/Non-Preferred are separate.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually but not always January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. Preferred \$600 Person/\$1200 per Family; Non-Preferred \$1500 Person/\$2000 per Family. Out of Pocket limits for Preferred & Non-Preferred are separate. Prescription drug out of pocket \$1250 Person & \$2500 Family. OVERALL IN NETWORK PLAN YEAR MAXIMUM OUT OF POCKET \$6600/SINGLE & \$13500/FAMILY INCLUDES ALL COPAYMENTS, DEDUCTIBLES, and COINSURANCE.	The out-of-pocket limit 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.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance billed charges, penalties and health care this plan doesn't cover. Copayments apply to your OVERALL Out of Pocket.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	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 chart starting on page 2 describes <i>specific</i> coverage limits, such as limits on the number of

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		office visits.
Does this plan use a network of providers?	Yes, for a list of preferred providers , see www.cigna.com or call 1-800-242-4472	If you use a preferred doctor or other health care provider , 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 provider for some services. Plans use the term in-net-work, preferred , or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist?	No	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .

- **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.

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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$10 copay/visit	Deductible then 30%	None
	Specialist visit	\$10 copay/visit	Deductible then 30%	Includes Chiropractor-up to 12 visits, approval need for additional visits; Nutritionist-Preferred Provider only
	Other practitioner office visit	\$10 copay/visit	Deductible then 30%	None
	Preventive care/screening/immunization	No charge	Deductible then 30%	None

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Employee Group Health Plan: City of Burlington

Coverage Period: 07/01/15-06/30/16

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

Coverage for: Employee/Dependent | Plan Type: PPO

If you have a test	Diagnostic test (x-ray, blood work)	Deductible then 20% coinsurance.	Deductible then 30% coinsurance.	
	Imaging (CT/PET scans, MRIs)	Deductible then 20% coinsurance	Deductible then 30% coinsurance	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com	Generic drugs & Brand name drugs if generic is not available	Retail: \$10 copay per 30 to 90 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	No charge	Not covered	Covers most diabetic medication & supplies.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible then 20% coinsurance	Deductible then 30%	None
	Physician/surgeon fees	Deductible then 20% coinsurance	Deductible then 30%	None
If you need immediate medical attention	Emergency room services	Deductible then 20% coinsurance	Deductible then 30%	Medical Emergency Only
	Emergency medical transportation	Deductible then 20% coinsurance	Deductible then 20% coinsurance	Nonemergency medical transportation requires approval.
	Urgent care	\$10 copay	\$10 copay	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 20% coinsurance	Deductible then 30%	Preauthorization required.
	Physician/surgeon fee	Deductible then 20% coinsurance	Deductible then 30%	Preauthorization required.

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If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$10 copay/visit	Deductible then 30%	None
	Mental/Behavioral health inpatient services	Deductible then 20% coinsurance	Deductible then 30%	Preauthorization required.
	Substance use disorder outpatient services	\$10 copay/visit	Deductible then 30%	None
	Substance use disorder inpatient services	Deductible then 20% coinsurance	Deductible then 30%	Preauthorization required.
If you are pregnant	Prenatal and postnatal care	Deductible then 20% coinsurance	Deductible then 30%	None
	Delivery and all inpatient services	Deductible then 20% coinsurance	Deductible then 30%	Preauthorization required for stay more than 48 hours normal delivery or 96 hours C-Section
If you need help recovering or have other special health needs	Home health care	Deductible then 20% coinsurance	Deductible then 30%	Preauthorization required.
	Rehabilitation services	Deductible then 20% coinsurance	100%	Inpatient: preauthorization required. Physical, Occupational & Speech therapy 30 visits each per calendar year

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	Habilitation services	Deductible then 20% coinsurance	100%	Inpatient: preauthorization required. Physical, Occupational & Speech therapy 30 visits each per calendar year
	Skilled nursing care	Deductible then 20% coinsurance	Deductible then 30%	60 day maximum per calendar year; preauthorization required.
	Durable medical equipment	Deductible then 20% coinsurance	Deductible then 30%	None
	Hospice service	Deductible then 20% coinsurance	Deductible then 30%	Preauthorization required.
<u>If your child under age 19 needs dental or eye care</u>	Eye exam	No Charge	No Charge	1 exam per calendar year
	Glasses	No Charge	No Charge	1 pair glasses or contacts
	Dental check up	No Charge	No Charge	2 exams & 2 cleanings per calendar

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 <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (adult) 	<ul style="list-style-type: none"> • Hearing Aids, • Infertility treatment • Long-term care 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine foot care and • 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
- Routine Eye Care (adult)

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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or 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
Total	\$7,540

Patient pays:

Deductibles	\$200
Copays	\$0
Coinsurance	\$200
Limits or exclusions	\$150
Total	\$550

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
Total	\$5,400

Patient pays:

Deductibles	\$200
Copays	\$100
Coinsurance	\$100
Limits or exclusions	\$80
Total	\$480

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.