**Wesleyan University: Choice Fund Open Access Plus HSA**

**Coverage Period:** 01/01/2016 - 12/31/2016

**Coverage for:** Individual/Individual + Family | **Plan Type:** OAP

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

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**Important Questions** | **Answers** | **Why this Matters:**
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**What is the overall deductible?** | For in-network providers $1,500 person / $3,000 family  
For out-of-network providers $1,500 person / $3,000 family  
Deductible per person applies when the employee is the only person covered under the plan.  
Does not apply to in-network preventive care & immunizations, outpatient professional services  
Amount your employer contributes to your account: Up to $500 person / $500 family. | 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 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.

**Are there other deductibles 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 out-of-pocket limit on my expenses?** | Yes. For in-network providers $3,000 person / $6,000 family / For out-of-network providers $3,000 person / $6,000 family  
Out-of-pocket limit for person applies when the employee is the only person covered under the plan. | 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 out-of-pocket limit?** | Premium, balance-billed charges, penalties for no pre-authorization, and health care this plan doesn’t cover. | 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. | The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.

**Does this plan use a network of providers?** | Yes. For a list of participating providers, see www.myCigna.com or call 1-800-Cigna24 | If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, 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 don't need a referral to see a specialist. | You can see the specialist you choose without permission from this plan.

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Questions: Call 1-800-Cigna24 or visit us at www.myCigna.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-Cigna24 to request a copy.
### Important Questions | Answers | Why this Matters:
--- | --- | ---
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**.

### Co-payments
- Co-payments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.

### Co-insurance
- Co-insurance is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** of the service. For example, if the health plan's **allowed amount** for an overnight hospital stay is $1,000, your co-insurance 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 charge is $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**, **co-payments** and **co-insurance** amounts.

### Common Medical Event | Services You May Need | Your Cost if you use an In-Network Provider | Out-of-Network Provider
--- | --- | --- | ---
**If you visit a health care provider's office or clinic**
- Primary care visit to treat an injury or illness
  - In-Network Provider: No charge after plan deductible
  - Out-of-Network Provider: 20% co-insurance after plan deductible
  - Limitations & Exceptions: None
- Specialist visit
  - In-Network Provider: No charge after plan deductible
  - Out-of-Network Provider: 20% co-insurance after plan deductible
  - Limitations & Exceptions: None
- Other practitioner office visit
  - In-Network Provider: No charge after plan deductible for Chiropractor
  - Out-of-Network Provider: 20% co-insurance after plan deductible
  - Limitations & Exceptions: Coverage for Chiropractic care and Rehabilitation services (includes Cardiac rehab) is limited to 60 days annual max.
- Preventive care/screening/immunization
  - In-Network Provider: No charge after plan deductible
  - Out-of-Network Provider: 20% co-insurance after plan deductible
  - Limitations & Exceptions: None

**If you have a test**
- Diagnostic test (x-ray, blood work)
  - In-Network Provider: No charge after plan deductible
  - Out-of-Network Provider: 20% co-insurance after plan deductible
  - Limitations & Exceptions: None
- Imaging (CT/PET scans, MRIs)
  - In-Network Provider: No charge after plan deductible
  - Out-of-Network Provider: 20% co-insurance after plan deductible
  - Limitations & Exceptions: None

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<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost if you use an In-Network Provider</th>
<th>Your Cost if you use an Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>20% co-insurance but not less than $5 or greater than $50/prescription (30 day supply-retail)</td>
<td>Not Covered</td>
<td>Coverage is limited up to a 30-day supply (retail) and up to a 90-day supply (retail &amp; home delivery)</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>25% co-insurance but not less than $15 or greater than $50/prescription (30 day supply-retail)</td>
<td>Not Covered</td>
<td>Coverage is limited up to a 30-day supply (retail) and up to a 90-day supply (retail &amp; home delivery)</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>25% co-insurance but not less than $20 or greater than $50/prescription (30 day supply-retail)</td>
<td>Not Covered</td>
<td>Coverage is limited up to a 30-day supply (retail) and up to a 90-day supply (retail &amp; home delivery)</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>No charge after plan deductible</td>
<td>20% co-insurance after plan deductible</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>20% co-insurance after plan deductible</td>
<td>none</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>No charge after plan deductible</td>
<td>No charge after plan deductible</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge after plan deductible</td>
<td>No charge after plan deductible</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>No charge after plan deductible</td>
<td>No charge after plan deductible</td>
<td>none</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost if you use an In-Network Provider</th>
<th>Your Cost if you use an Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>No charge after plan deductible</td>
<td>20% co-insurance after plan deductible</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge after plan deductible</td>
<td>20% co-insurance after plan deductible</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>No charge after plan deductible</td>
<td>20% co-insurance after plan deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>No charge after plan deductible</td>
<td>20% co-insurance after plan deductible</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>No charge after plan deductible</td>
<td>20% co-insurance after plan deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>No charge after plan deductible</td>
<td>20% co-insurance after plan deductible</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>No charge after plan deductible</td>
<td>20% co-insurance after plan deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>No charge after plan deductible</td>
<td>20% co-insurance after plan deductible</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge after plan deductible</td>
<td>20% co-insurance after plan deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>No charge after plan deductible</td>
<td>20% co-insurance after plan deductible</td>
<td>Coverage for Rehabilitation, including Cardiac rehab and Chiropractic care, services is limited to 60 days annual max.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No charge after plan deductible</td>
<td>20% co-insurance after plan deductible</td>
<td>50% penalty for no precertification. Coverage is limited to 90 days annual max.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>No charge after plan deductible</td>
<td>20% co-insurance after plan deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge after plan deductible</td>
<td>20% co-insurance after plan deductible</td>
<td>50% penalty for no precertification.</td>
</tr>
</tbody>
</table>

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### Common Medical Event

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost if you use an</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your child needs dental or eye care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>-------------------------</td>
</tr>
</tbody>
</table>

#### 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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

**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.)

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment

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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 the plan at 1-800-Cigna24. 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.

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 Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

-------------------To see examples of how this plan might cover costs for a sample medical situation, see the next page.----------
### Coverage Examples
#### 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. Please consider any contributions you may receive in an HRA, HSA or FSA.

**Note:** These numbers assume enrollment in individual-only coverage.

<table>
<thead>
<tr>
<th>Having a baby</th>
<th>Managing type 2 diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>(normal delivery)</td>
<td>(routine maintenance of a well-controlled condition)</td>
</tr>
<tr>
<td><strong>Amount owed to providers:</strong> $7,540</td>
<td><strong>Amount owed to providers:</strong> $5,400</td>
</tr>
<tr>
<td><strong>Plan pays:</strong> $6,000</td>
<td><strong>Plan pays:</strong> $2,940</td>
</tr>
<tr>
<td><strong>Patient pays:</strong> $1,540</td>
<td><strong>Patient pays:</strong> $2,460</td>
</tr>
</tbody>
</table>

#### Sample care costs:

<table>
<thead>
<tr>
<th>Having a baby</th>
<th>Managing type 2 diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine Obstetric Care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$7,540</td>
</tr>
<tr>
<td>Patient pays:</td>
<td></td>
</tr>
<tr>
<td>Deductible</td>
<td>$1,500</td>
</tr>
<tr>
<td>Co-pays</td>
<td>$10</td>
</tr>
<tr>
<td>Co-insurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$30</td>
</tr>
</tbody>
</table>
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 pre-existing 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, co-payments, and co-insurance 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 co-payments, deductibles, and co-insurance. You also should 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.

Plan ID: 4415911  BenefitVersion: 6
Plan Name: HSA