HealthAssurance Pennsylvania, Inc: Juniata College Premier PPO 99095

Coverage Period : 01/01/2013 - 12/31/2013

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Employee, Family **| Plan Type:** PPO

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.healthamerica.cvty.com or by calling Central/Eastern Pennsylvania 1-800-252-5742.

Important Questions	Answers	Why This Matters:
What is the overall **deductible**?	In Network: None Out of Network: $300/ $600	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 **deductibles**.
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?	In Network: No Out of Network: Yes. $2,000/ $4,000	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**?	Deductible, Copays, Premiums, balance-billed charges, services this health 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.healthamerica.cvty.com or call 1-800-252-5742.	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 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**.

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- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **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 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 a		Limitations & Exceptions
		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	$10 Copay (per visit)	20% Eligible Charges (after annual deductible)	None
	Specialist visit	$10 Copay (per visit)	20% Eligible Charges (after annual deductible)	None
	Other practitioner office visit	$10 Copay per visit for spinal manipulation (chiropractic care)	20% Eligible Charges (after annual deductible)	Limited to 25 visits (combined in and out of network) per calendar year.
	Preventive care/ Screening/Immunization	$10 Copay	20% Eligible Charges (after annual deductible)	Covered only as required by state and federal mandates.
If you have a test	Diagnostic test (x-ray, blood work)	0% Coinsurance x-ray 0% Coinsurance lab	20% Eligible Charges (after annual deductible) x-ray 20% Eligible Charges (after annual deductible) lab	None

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In Network Provider	Out of Network Provider	
If you have a test	Imaging (CT/PET scans, MRIs)	0% Coinsurance	20% Eligible Charges (after annual deductible)	----------none----------
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.healthamerica.cvty.com.	Generic drugs	Retail: $3.00 Tier 1A, $10 Generic. Mail Order: $6.00 Tier 1A, $20 Generic	Not Covered	90-day supply of plan-approved 'maintenance medications' available at network retail pharmacies. Tier 1A and Tier 1 generics ONLY.
	Preferred brand drugs	Retail: 10%, Min $20 Max $100. Mail Order: $40	Not Covered	$50 deductible, Brand Only (per person/per calendar year)
	Non-preferred brand drugs	Retail: 10%, Min $40 Max $100. Mail Order: $80	Not Covered	----------none----------
	Specialty drugs			See Summary Plan Description for details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$10 copay (per procedure)	20% Eligible Charges (after annual deductible)	Not covered without Prior Authorization.
	Physician/surgeon fees	$10 Copay (per procedure)	20% Eligible Charges (after annual deductible)	Not covered without Prior Authorization.
If you need immediate medical attention	Emergency room services	$25 Copay per visit (waived if admitted)	$25 Copay per visit (waived if admitted)	Must meet emergency criteria. Non-Emergency visit subject to $25 Copay per visit in network, 20% of Eligible Charges (after annual deductible) out of network.
	Emergency medical transportation	0% Coinsurance	0% Coinsurance	Must meet emergency criteria.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In Network Provider	Out of Network Provider	
If you need immediate medical attention	Urgent care	$10 Copay (per visit)	$10 Copay (per visit)	Must meet urgent care criteria.
If you have a hospital stay	Facility fee (e.g., hospital room)	$25 Copay (per admission)	20% Eligible Charges (after annual deductible)	Not covered without Prior Authorization.
	Physician/surgeon fee	$25 Copay (per admission)	20% Eligible Charges (after annual deductible)	Not covered without Prior Authorization.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 Copay (per visit)	20% Eligible Charges (after annual deductible)	Not covered without Prior Authorization.
	Mental/Behavioral health inpatient services	$25 Copay (per admission)	20% Eligible Charges (after annual deductible)	Not covered without Prior Authorization.
	Substance use disorder outpatient services	$10 Copay (per visit)	20% Eligible Charges (after annual deductible)	Not covered without Prior Authorization.
	Substance use disorder inpatient services	$25 Copay (per admission)	20% Eligible Charges (after annual deductible)	Not covered without Prior Authorization.
If you are pregnant	Prenatal and postnatal care	$10 Copay (per visit)	20% Eligible Charges (after annual deductible)	Prenatal Copay applied to first visit only.
	Delivery and all inpatient services	0% Coinsurance	20% Eligible Charges (after annual deductible)	Not covered without Prior Authorization.

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Common Medical Event	Services You May Need	Your cost if you use a In Network Provider	Your cost if you use a Out of Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	0% Coinsurance	20% Eligible Charges (after annual deductible)	Not covered without Prior Authorization. Limited to 120 in-network visits and 60 out-of-network visits per calendar year. Combined limit of 120 visits in and out of network.
	Rehabilitation services	Inpatient $25 Copay (per admission) Outpatient $10 Copay (per visit)	Inpatient 20% Eligible Charges (after annual deductible) Outpatient 20% Eligible Charges (after annual deductible)	Inpatient Not covered without Prior Authorization. Limited to 45 inpatient days and 60 outpatient visits per calendar year.
	Habilitation services	Not Covered	Not Covered	Covered only as required by state and federal mandates.
	Skilled nursing care (facility)	$25 Copay (per admission)	20% Eligible Charges (after annual deductible)	Not covered without Prior Authorization. Combined limit of 90 inpatient days both in and out of network.
	Durable medical equipment (including supplies)	0% Coinsurance	20% Eligible Charges (after annual deductible)	Not covered without Prior Authorization. Limited to once every 2 years for irreparable damage and/or normal wear.
	Hospice Services	0% Coinsurance	20% Eligible Charges (after annual deductible)	Not covered without Prior Authorization.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Excluded Service
	Glasses	Not Covered	Not Covered	Discounts available through Vision One Eyecare Program, see plan details.
	Dental check-up	Not Covered	Not Covered	Excluded Service

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy for others.)		
• Acupuncture	• Bariatric Surgery	• Child//Eye exam
• Child/Dental Check-up	• Child/Glasses	• Cosmetic Surgery
• Dental Care (Adult)	• Habilitation services	• Hearing Aids
• Infertility Treatment	• Long-Term Care	• Non-Emergency Care when Traveling Outside the U.S.
• Routine Eye Care (Adult)	• Routine Foot Care	

Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)		
• Chiropractic Care	• Private-Duty Nursing	• Weight Loss Programs

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 Central/Eastern Pennsylvania 1-800-252-5742. 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 Appeals and Grievances:

For group health coverage subject to ERISA, you may contact Central/Eastern Pennsylvania 1-800-252-5742. 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, or your state department of insurance at Ohio Department of Insurance ATTN: Consumer Affairs 50 West Town Street, Suite 300 Columbus, OH 43215 614-644-2673 800-686-1526 (Toll Free) 614-644-3745 (TDD) Fax: 614-644-3744 Contact ODI Consumer Affairs: https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp Pennsylvania Department of Insurance Bureau of Consumer Services 1209 Strawberry Square Harrisburg, Pennsylvania 17120 717-787-2317 877-881-6388 (Toll Free) TTY/TDD: 717-783-3898 Fax: 717-787-8585 Email: ra-in-consumer@pa.gov.

For non-federal governmental group health plans and church plans that are group health plans, you may contact Central/Eastern Pennsylvania 1-800-252-5742 or your state department of insurance at Ohio Department of Insurance ATTN: Consumer Affairs 50 West Town Street, Suite 300 Columbus, OH

43215 614-644-2673 800-686-1526 (Toll Free) 614-644-3745 (TDD) Fax: 614-644-3744 Contact ODI Consumer Affairs: https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp Pennsylvania Department of Insurance Bureau of Consumer Services 1209 Strawberry Square Harrisburg, Pennsylvania 17120 717-787-2317 877-881-6388 (Toll Free) TTY/TDD: 717-783-3898 Fax: 717-787-8585 Email: ra-in-consumer@pa.gov.

Additionally, a consumer assistance program can help you file your appeal. Contact Pennsylvania Department of Insurance 1209 Strawberry Square Harrisburg, PA 17111 (877) 881-6388 www.insurance.pa.gov

Language Access Services:

Spanish (Espanol): Para obtener asistencia en Espanol, llame al Central/Eastern Pennsylvania 1-800-252-5742.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa Central/Eastern Pennsylvania 1-800-252-5742.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 Central/Eastern Pennsylvania 1-800-252-5742.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' Central/Eastern Pennsylvania 1-800-252-5742.

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

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 insurance protection you might get from 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 the 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:** $6,945
- **You pay:** $595

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**

You pay:

Deductibles	$0
Co-pays	$6
Coinsurance	$439
Limits or exclusions	$150
Total	**$595**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,747
- **You pay:** $653

Sample care costs:

Prescriptions	$2,900
Medical equipment and supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccine, other preventive	$100
Total	**$5,400**

You pay:

Deductibles	$0
Co-pays	$554
Coinsurance	$20
Limits or exclusions	$79
Total	**$653**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: Central/Eastern Pennsylvania 1-800-252-5742

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.

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