Susquehanna University
HMO
Administered by GIIC
Summary of Benefits
01/01/2023

Deductible

$750 single
$1,500 family

Deductible must be satisfied every coverage period before coinsurance applies.
Copayments do not apply to the deductible.

Coinsurance

20%

Coinsurance Maximum
Deductible does not apply to coinsurance maximum.

$1,500 single
$3,000 family

Maximum Out of Pocket
Medical and RX combined

$9,000 single
$18,200 family

Services covered when medically necessary	You Pay
PCP Office Services	
Office visits.	$20 copay
Periodic health assessments/routine physicals.	$0
Specialist Office Services	
Office visits.	$40 copay
Office procedures.	20% after deductible
Outpatient Services	
Outpatient surgery.	20% after deductible
Telehealth (virtual visit)	
Primary care physician	$5 copay
Specialist physician	$10 copay
Behavioral health and substance abuse therapy	$0 copay
Preventive Services: For a Full list of preventive services refer to healthcare.gov/coverage/preventive-care-benefits. All PPACA Preventive Services including but not limited to:	
Mammograms.	$0
Immunizations covered in accordance with accepted medical practices, excluding immunizations necessary for international travel.	$0
Pap smears.	$0
Chlamydia screening ages 16-25.	$0
Dexa scan.	$0
Fecal occult blood testing.	$0
Cholesterol screening.	$0
Diabetes care including HbA1c testing, LDL-C screening and nephropathy screening.	$0
Lipid panel.	$0

Newborn screening: one hematocrit and hemoglobin screening for infants under 24 months.	$0
Colorectal Cancer Screening	
Colorectal cancer screening, limited to flexible sigmoidoscopy, colonoscopy and related services covered 100%. Note: preparation medication is not covered under the medical benefit. However, preparation medication may be covered under your pharmacy benefit, which will be subject to your normal pharmacy benefit cost-sharing.	$0
Well-Child Services	
Well-child office visits (age 0-21)	$0
Testing Services	
X-rays, laboratory and other diagnostic tests.	20% after deductible
Computed Axial Tomography (CAT Scan), Magnetic Resonance Imaging (MRI), and Position Emission Tomography (PET Scan), Magnetic Resonance Angiography (MRA) and nuclear cardiology.	20% after deductible
All Other Diagnostic Services	
Ostomy supplies.	20% after deductible
Medically necessary urological supplies.	20% after deductible
Other diagnostic services.	20% after deductible
Well-Woman Care	
Annual gynecological examination.	$0
Maternity Care	
Maternity care by your physician before and after the birth of your baby.	20% after deductible
Maternity hospitalization.	20% after deductible
Hospitalization	
Medical and surgical specialist care, including anesthesia.	20% after deductible
Care in a semi-private room at a participating facility. Includes intensive care, cardiac care unit services, obstetrical care, newborn care, medications, diagnostic tests and transplant services.	20% after deductible
Surgery for Correction of Obesity (cost sharing does not apply to maximum out-of-pocket)	
Facility charges.	20% after deductible
Professional charges.	20% after deductible
Infertility Treatment	
Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy is not covered.	20% after deductible
Emergency Services	
Emergency care.	$150 (waived if admitted to hospital)
Ambulance services to and from hospital.	$0
Critical response air transport.	$0
Urgent care.	$20 copay
Other Therapy Services	

Physical, Occupational and Speech Therapy.	$40 copay
Cardiac rehabilitation, outpatient.	20% after deductible
Pulmonary rehabilitation benefit, outpatient (unlimited).	20% after deductible
High cost specialty drugs.	20% after deductible
Infusion therapy.	20% after deductible
Chemotherapy.	20% after deductible
Radiation therapy.	20% after deductible
Dialysis.	20% after deductible
Diabetes Services and Supplies [1]	
Diabetic eye examination.	$0
Prescription/supply coverage: LifeScan test strips (OneTouch, OneTouch Ultra, and OneTouch Verio) and lancets are covered. The following may be limited to specific vendors: insulin, syringes and needles for the administration of insulin only, oral agents used to control blood sugar (1 copayment/30 day supply) and Glucagon emergency kit (two per copayment).	Tier 1: $10 generic copay Tier 2: $40 formulary brand copay Tier 3: $90 non-formulary brand copay Tier 4: Specialty Drugs-$125 per prescription 2 (two) refills then mandatory mail order supply for maintenance medications.
Diabetic foot orthotics.	20% after deductible
Home blood glucose monitors: LifeScan brand diabetic supplies only. Must be purchased at a participating pharmacy.	$0
Diabetic medical equipment: The following may be limited to specific vendors: injection aids, insulin pumps, syringe reservoirs and infusion sets.	$0
[1] The Plan reserves the right to restrict vendors and apply quantity limitations.	
Skilled Nursing/Home Health Services	
Short-term, non-custodial medical care in a licensed, skilled nursing facility, as approved by a Plan physician and the Plan, for up to 100 days.	20% after deductible
Home health care. Limited to 90 visits per calendar year.	20% after deductible
Hospice care: home and inpatient care including home health aide and homemaker services, counseling and medical social services.	20% after deductible
Implanted Devices (medical and contraceptive)	
Drug delivery.	20% after deductible
Contraceptives	$0
Durable Medical Equipment	
Equipment which can stand repeated use, such as wheelchairs, hospital beds and oxygen equipment. Standard equipment is covered when prescribed by a participating provider, purchased from a participating vendor. The Plan reserves the right to restrict vendor.	20% after deductible
Prosthetic Devices	
Externally worn appliance or apparatus which replaces a missing body part, such as artificial limbs. Must be prescribed by participating provider. Medically necessary replacements covered every 5 years.	20% after deductible
Orthotic Devices	
Rigid appliance used to support, align or correct bone and muscle deformities. Must be prescribed by participating provider.	20% after deductible

Alcohol and Drug Abuse Treatment	
Inpatient detoxification.	10% after deductible
Non-hospital residential inpatient rehabilitation.	10% after deductible
Outpatient rehabilitation at an alcoholism/drug abuse facility.	$20 copay
Outpatient Opioid Detoxification Treatment	
Detoxification.	10% after deductible
Buprenorphine and buprenorphine/naloxone are covered as part of this treatment.	10% after deductible
Mental Health	
Mental health care by psychiatrist, licensed clinical psychologist or other licensed behavioral health professional.	$0
Serious Mental Illness (SMI) Services	
Care provided for the following serious mental illnesses: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder.	10% after deductible/ inpatient facility 10% after deductible/inpatient professional visit 10% after deductible/partial hospitalization day
Non-Serious Mental Illness Services	
Non-Serious mental illnesses that exclude schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder.	10% after deductible inpatient facility 10% after deductible/inpatient professional visit 10% after deductible/partial hospitalization day
Autism Spectrum Disorder Rider	
Care provided for members under 21 years of age for the treatment of autism spectrum disorders (as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental disorders (DSM), or its successor including autistic disorder, Asperger's disorder and Pervasive Development Disorder not otherwise specified.) which includes, pharmacy, psychiatric and psychological, rehabilitative and therapeutic care.	
Pharmacy care	Copayment per outpatient prescription drug benefit
Psychiatric and Psychological Care: direct or consultative services provided by a psychiatrist or psychologist.	$0
Rehabilitative Care: professional services and treatment programs, including applied behavioral analysis, provided by an autism service provider to produce socially significant improvements in human behavior or to prevent loss of attained skill or function.	20% deductible does not apply
Therapeutic Care: includes services provided by speech pathologists, occupational therapists or physical therapists.	$40 copay / visit

Additional Services	You Pay
Fourth Tier Pharmacy Benefit [2]	
31-day supply per copayment for outpatient prescription drugs from a participating pharmacy. Most covered drugs are listed on the formulary, a continually updated list of commonly covered drugs. Each drug assigned to a tier. Tier 1: most generic drugs; prior authorization is generally not required. Tier 2: certain generic drugs and formulary brand name drugs with no generic equivalent; prior authorization may be required. Tier 3: some formulary brand name drugs with generic equivalents, other brand name drugs, and non-formulary drugs if approved; prior authorization may be required. Tier 4: formulary specialty brand name and generic; prior authorization may be required. Quantity limits per prescription (less than a 34 day supply) may apply. Provider must request prior authorization. For information call Pharmacy Services at (800) 988-4861. *You are responsible for the payment differential when a generic drug is authorized by your provider and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment amount.*	Tier 1: $10 generic copay Tier 2: $40 formulary brand copay Tier 3: $90 non-formulary brand copay Tier 4: Specialty Drugs-$125 per prescription 2 (two) refills then mandatory mail order supply for maintenance medications.

Contraceptives; includes diaphragms.	$0 generic/brand name drugs with no generic equivalent
Mail Order Pharmacy. 90 day supply per copayment. Prescriptions can be received through the mail by using the Plan's mail order pharmacy program. A doctor's prescription, copayment and completed form is required.	Tier 1: $25 generic copay Tier 2: $100 formulary brand copay Tier 3: $225 non-formulary brand copay
[2] The Plan reserves the right to restrict vendors and apply quantity limitations.	
Impacted Wisdom Teeth Extraction	
Oral surgery for extraction of partially or totally bony impacted third molars. Service covered in the physician's office. Hospital and ambulatory surgical center services are not covered.	20% after deductible
Manipulative Treatment Services Rider	
Direct access to participating providers for chiropractic services which may include patient exams, manipulation, adjunctive therapy and X-rays. Chiropractic appliances covered up to $50 per benefit year when prescribed by a participating provider. Maximum 20 visits/ benefit year.	$40 copay
Please review individual rider documents for limitations and exclusions.	

Additional Discounts

Through our Accessories Program, you have access to money-saving discounts on a host of health-related products and services, with no referral necessary.

Acupuncture	Chiropractic care	Eyewear and eye exams
Fitness centers memberships	LASIK vision correction	Mail order contact lenses
Massage therapy	Safe Beginnings ®	

Member Information

We want our members to be well informed. The following information is available by contacting our Customer Care Team at (800) 504-0443.

Geisinger Health Plan Board of Directors	Summary of provider reimbursement methodologies	Provider List and/or monthly Provider List Updates
Description of process for Formulary exception	Procedures for covering experimental drugs/procedures	Pharmacy formulary
Provider credentialing process	Summary of quality assurance program	Provider privileges at contracted hospitals

Important information, definitions, and limitations

Case Management a service where Plan nurses assist members with serious conditions to obtain appropriate support and services so that members can achieve their optimal level of health.

Concurrent review a process to ensure that medically necessary, appropriate care is delivered to a hospitalized member.

Confidentiality the Plan's confidentiality policy protects members' privacy of their personal health information including medical records, claims, benefits and other administrative data in all settings. The policy also prohibits sharing personal health information with employers including fully insured employers. However, as a member you always have access to your medical records. Upon enrollment, members sign routine consent forms which allow the Plan to use your information to conduct its business like paying claims and for measurement of data where members identifiers are removed to assure confidentiality. For release of any other personal information, except when required by law, you will be asked to sign a special consent form. A complete copy of the confidentiality policy is available by contacting the Customer Care Team.

Continuity of care for new members (Act 68) Under the provisions of Act 68, a new member can continue on-going treatment with a non-participating physician for the first 60 days of enrollment. If a member is in her second or third trimester of pregnancy, services will be covered through delivery and postpartum care. To initiate this request, the member must contact the Customer Care Team prior to receiving treatment. The Plan will confer with the provider to determine if the provider will accept the Plan's terms and conditions for payment. If the provider does not agree, the services of the non-participating provider will not be covered.

Covered services Covered services that are not available within the Plan's network or are out of the Plan's service area must be authorized in advance by the Plan.

Medical Necessity or Medically Necessary covered services rendered by a health care provider that the Plan determines are: a) appropriate for the symptoms and diagnosis or treatment of the member's condition, illness, disease or injury; b) provided for the diagnosis, or the direct care and treatment of the member's condition, illness, disease or injury; c) in accordance with current standards of medical practice; d) not primarily for the convenience of the member, or the member's provider; and e) the most appropriate source or level or service that can safely be provided to the member. When applied to hospitalization, this further means that the member requires acute care as an inpatient due to the nature of the services rendered or the member's condition, and the member cannot receive safe or adequate care as an outpatient.

Prior authorization the process by which approval is given by the Plan for covered services based on medical necessity, eligibility and benefit availability at the time the covered services are to be provided prior to the services being performed.

PCP primary care physician.

Retrospective review to determine the appropriateness of treatment, the Plan will complete a post-clinical review when necessary to determine whether or not the treatment met coverage guidelines. Based on this review, claims associated with treatment will be approved or denied.

This document is intended as an easy-to-read summary. Benefits, limitations and exclusions are provided in accordance with the Subscription Certificate and applicable riders under which a member is enrolled. This managed care plan may not cover all your health care expenses. Read your Subscription Certificate and riders carefully to determine which health care services are covered.