Susquehanna University
Solutions HMO
Administered by GIIC
Summary of Benefits
01/01/2020

Deductible Deductible must be satisfied every coverage period before coinsurance applies. Copayments do not apply to the deductible.	$500 single $1,000 family
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	$7,350 single $14,700 family

SERVICES covered when medically necessary	You Pay
PCP Office Services	
PCP office visit.	$20 copay
Periodic health assessments/routine physicals	$0
Preventive Services. For a Full list of preventive services refer to https://www.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 for females ages 16-25.	$0
Dexa scan. (Bone density 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.	$0
Well-Child Services	
Well-child office visits (age 0-21)	$0
Testing Services	
X-rays and other diagnostic tests.	20% after deductible
Lab services	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
Specialist Office Services	
Office visits.	$40 copay

Annual gynecological examination	$0
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
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	
Facility charges.	20% after deductible
Professional charges.	20% after deductible
Emergency Services	
Emergency care.	$150 copay (waived if admitted to hospital)
Ambulance service to and from hospital.	$0
Critical response air transport.	$0
Urgent care.	$50 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 (One-Touch, One-Touch Ultra, SureStep and FastTake) 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: $80 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.	20% after deductible
Diabetic medical equipment: The following may be limited to specific vendors: injection aids, insulin pumps, syringe reservoirs and infusion sets.	20% after deductible
[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[2]	
Inpatient detoxification.	20% after deductible
Non-hospital residential inpatient rehabilitation.	20% after deductible
Outpatient rehabilitation at an alcoholism/drug abuse facility.	$20 copay
[2]No PCP referral required. Services must be provided by facilities participating with the Plan's behavioral health manager. Call (888) 839- 7972 for more information. Pre-authorization is required for all services except routine outpatient visits.	
Outpatient Opioid Detoxification Treatment[3]	
Detoxification	20% after deductible
Subutex and Suboxone are covered as part of this treatment.	20% after deductible inpatient/partial hospitalization
[3]No PCP referral required. Services must be provided by facilities participating with the Plan's behavioral health manager. Call (888) 839- 7972 for more information. Pre-authorization is required for all services except routine outpatient visits.	
Autism Spectrum Disorder	
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 suggessor 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	Covered per outpatient prescription drug benefit
Psychiatric and Psychological Care: direct or consultative services provided by a psychiatrist or psychologist.	$20 copay/session
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% after deductible
Therapeutic Care: includes services provided by speech pathologists, occupational therapists or physical therapists.	$40 copay/visit
Mental Health[4]	
Mental health care by psychiatrist, licensed clinical psychologist or other licensed behavioral health professional.	$20 copay
[4]Services must be provided by facilities participating with the Plan's behavioral health manager. Call (888) 839- 7972 for more information. Pre-authorization is required for all services except routine outpatient visits.	
Serious Mental Illness (SMI)[5]	
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. Care for these conditions by a participating provider facility.	20% after deductible inpatient facility 20% after deductible/inpatient professional visit 20% after deductible/partial hospitalization
[5]Services must be provided by facilities participating with the Plan's behavioral health manager. Call (888) 839- 7972 for more information. Pre-authorization is required for all services except routine outpatient visits.	
Non-Serious Mental Illness[6]	
Non-Serious mental illnesses that exclude schizophrenia, bipolar disorder, obsessive compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulemia nervosa, schizo-affective disorder and delusional disorder. Care for acute short-term psychiatric conditions in a participating provider facility: No PCP referral required.	20% after deductible inpatient facility 20% after deductible/inpatient professional visit 20% after deductible/partial hospitalization
[6]Services must be provided by facilities participating with the Plan's behavioral health manager. Call (888) 839-7972 for more information. Pre- authorization is required for all services except routine outpatient visits.	

Triple Choice Option for Outpatient Prescription Drugs	
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. Prior authorization may be required. 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: $80 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: $200 non-formulary brand copay
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
Therapeutic Adjustment Services	
Manipulative treatment, electrical stimulation-attended, ultrasound, exercise therapy for strength and endurance and range of motion, re-education posture and proprioception, and exercise therapy to improve functional performance. Services must be performed by a participating provider. Maximum: 20 visits/benefit year.	$40 copay
Please review the Plan Document for limitations and exclusions.	