2016 Summary of Benefits

Preferred Advantage Rx (PPO)
Preferred Complete Rx (PPO)

Summary Of Benefits
January 1, 2016 - December 31, 2016

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover, or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

You have choices about how to get your Medicare benefits. One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government. Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Geisinger Gold Preferred Advantage Rx (PPO) and Preferred Complete Rx (PPO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Geisinger Gold Preferred Advantage Rx (PPO) and Preferred Complete Rx (PPO)** cover and what you pay. If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov. If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About **Geisinger Gold Preferred Advantage Rx (PPO) and Preferred Complete Rx (PPO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits
- Optional Benefits (you must pay an extra premium for these benefits)

This document is available in other formats such as Braille and large print. This document may be available in a non-English language. For additional information, call us at (800)-498-9731.

Things to Know About Geisinger Gold Preferred Advantage Rx (PPO) and Preferred Complete Rx

Hours of Operation

From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time.

From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time.

Geisinger Gold Preferred Advantage Rx (PPO) and Preferred Complete Rx (PPO) Phone Numbers and Website

If you are a member of this plan, call toll-free (800)-498-9731
If you are not a member of this plan, call toll-free (800)-514-0138
Our website: http://www.GeisingerGold.com

Who can join?

To join **Geisinger Gold Preferred Advantage Rx (PPO) or Preferred Complete Rx (PPO)** , you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Pennsylvania: Adams, Berks, Blair, Cambria, Cameron, Carbon, Centre, Clearfield, Clinton, Columbia, Cumberland, Dauphin, Fulton, Huntingdon, Jefferson, Juniata, Lackawanna, Lancaster, Lebanon, Lehigh, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northampton, Northumberland, Perry, Pike, Potter, Schuylkill, Snyder, Somerset, Sullivan, Susquehanna, Tioga, Union, Wayne, Wyoming, York.

Which doctors, hospitals, and pharmacies can I use?

Geisinger Gold Preferred Advantage Rx (PPO) and Preferred Complete Rx (PPO) have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. You can see our plan's provider and pharmacy directory at our website (http://www.GeisingerGold.com). Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers - and *more*. **Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less. **Our plan members also get *more than what is* covered by Original Medicare.** Some of the extra benefits are outlined in this booklet. We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, http://www.GeisingerGold.com. Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

If you have any questions about this plan's benefits or costs, please contact Geisinger Gold for details.

Summary of Benefits

Benefit	Preferred Advantage Rx (PPO)	Preferred Complete Rx (PPO)
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES		
How much is the monthly premium?	The monthly premium for **Geisinger Gold Preferred Advantage Rx (PPO)** is $69 per month. In addition, you must keep paying your Medicare Part B premium.	The monthly premium for **Geisinger Gold Preferred Complete Rx (PPO)** is $0 per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	This plan does not have a deductible.	This plan does not have a deductible.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $6,700 for services you receive from in-network providers. • $6,700 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $6,700 for services you receive from in-network providers. • $6,700 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.
Geisinger Gold Medicare Advantage HMO, PPO, and HMO SNP plans are offered by Geisinger Health Plan/Geisinger Indemnity Insurance Company, health plans with a Medicare contract. Continued enrollment in Geisinger Gold depends on annual contract renewal.	Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.

Summary of Benefits

Benefit	Preferred Advantage Rx (PPO)	Preferred Complete Rx (PPO)
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain benefits from any provider. Contact us for services that apply.	Our plan has a coverage limit every year for certain benefits from any provider. Contact us for services that apply.
COVERED MEDICAL AND HOSPITAL BENEFITS **NOTE: SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION.** **SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.**		
OUTPATIENT CARE AND SERVICES **Acupuncture**	Not covered	Not covered
Ambulance	• In-network: $200 copay • Out-of-network: $200 copay If you are admitted to the hospital, you do not have to pay for the ambulance services.	• In-network: $190 copay • Out-of-network: $190 copay If you are admitted to the hospital, you do not have to pay for the ambulance services.
Chiropractic Care	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • In-network: $20 copay • Out-of-network: $20 copay	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • In-network: $20 copay • Out-of-network: $20 copay
Dental Services[1]	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • In-network: $25 copay • Out-of-network: $25 copay	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • In-network: $40 copay • Out-of-network: $40 copay

Summary of Benefits

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Diabetes Supplies and Services[1]	Diabetes monitoring supplies: • In-network: 0-20% of the cost, depending on the supply • Out-of-network: 0-20% of the cost, depending on the supply Diabetes self-management training: • In-network: You pay nothing • Out-of-network: You pay nothing Therapeutic shoes or inserts: • In-network: 20% of the cost • Out-of-network: 0-20% of the cost, depending on the supply	Diabetes monitoring supplies: • In-network: 0-20% of the cost, depending on the supply • Out-of-network: 0-20% of the cost, depending on the supply Diabetes self-management training: • In-network: You pay nothing • Out-of-network: You pay nothing Therapeutic shoes or inserts: • In-network: 20% of the cost • Out-of-network: 0-20% of the cost, depending on the supply
Diagnostic Tests, Lab and Radiology Services, and X-Rays *(costs for these services may vary based on place of service)*[1]	Diagnostic radiology services (such as MRIs, CT scans): • In-network: $25-175 copay, depending on the service • Out-of-network: $25-175 copay, depending on the service Diagnostic tests and procedures: • In-network: $20 copay • Out-of-network: $20 copay Lab services: • In-network: $20 copay • Out-of-network: $20 copay Outpatient x-rays: • In-network: $20 copay • Out-of-network: $20 copay Therapeutic radiology services (such as radiation treatment for cancer): • In-network: $25-60 copay, depending on the service • Out-of-network: $25-60 copay, depending on the service	Diagnostic radiology services (such as MRIs, CT scans): • In-network: $35-260 copay, depending on the service • Out-of-network: $35-260 copay, depending on the service Diagnostic tests and procedures: • In-network: $25 copay • Out-of-network: $25 copay Lab services: • In-network: $25 copay • Out-of-network: $25 copay Outpatient x-rays: • In-network: $25 copay • Out-of-network: $25 copay Therapeutic radiology services (such as radiation treatment for cancer): • In-network: $35-60 copay, depending on the service • Out-of-network: $35-60 copay, depending on the service
Doctor's Office Visits	Primary care physician visit: • In-network: $5 copay • Out-of-network: $5 copay Specialist visit: • In-network: $25 copay • Out-of-network: $25 copay	Primary care physician visit: • In-network: $5 copay • Out-of-network: $5 copay Specialist visit: • In-network: $40 copay • Out-of-network: $40 copay

Summary of Benefits

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Durable Medical Equipment *(wheelchairs, oxygen, etc.)*[1]	• In-network: 20% of the cost • Out-of-network: 20% of the cost	• In-network: 20% of the cost • Out-of-network: 20% of the cost
Emergency Care	• $75 copay If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.	• $75 copay If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.
Foot Care *(podiatry services)*	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: $25 copay • Out-of-network: $25 copay Routine foot care (for up to 4 visit(s) every year): • In-network: You pay nothing • Out-of-network: You pay nothing	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: $40 copay • Out-of-network: $40 copay Routine foot care (for up to 4 visit(s) every year): • In-network: You pay nothing • Out-of-network: You pay nothing
Hearing Services	Exam to diagnose and treat hearing and balance issues: • In-network: $25 copay • Out-of-network: $25 copay	Exam to diagnose and treat hearing and balance issues: • In-network: $40 copay • Out-of-network: $40 copay
Home Health Care[1]	• In-network: You pay nothing • Out-of-network: You pay nothing	• In-network: You pay nothing • Out-of-network: You pay nothing

Summary of Benefits

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Mental Health Care[1]	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. • In-network: $200 copay per stay • Out-of-network: $200 copay per stay Outpatient group therapy visit: • In-network: $10 copay • Out-of-network: $10-25 copay, depending on the service Outpatient individual therapy visit: • In-network: $25 copay • Out-of-network: $10-25 copay, depending on the service	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days: • In-network: $190 copay per day for days 1 through 8. You pay nothing per day for days 9 through 90 • Out-of-network: $190 copay per day for days 1 through 8. You pay nothing per day for days 9 through 90 Outpatient group therapy visit: • In-network: $10 copay • Out-of-network: $10-25 copay, depending on the service Outpatient individual therapy visit: • In-network: $25 copay • Out-of-network: $10-25 copay, depending on the service

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Outpatient Rehabilitation[1]	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): • In-network: $10 copay • Out-of-network: $10 copay Occupational therapy visit: • In-network: $25 copay • Out-of-network: $25 copay Physical therapy and speech and language therapy visit: • In-network: $25 copay • Out-of-network: $25 copay	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): • In-network: $10 copay • Out-of-network: $10 copay Occupational therapy visit: • In-network: $40 copay • Out-of-network: $40 copay Physical therapy and speech and language therapy visit: • In-network: $40 copay • Out-of-network: $40 copay
Outpatient Substance Abuse[1]	Group therapy visit: • In-network: $10 copay • Out-of-network: $10-25 copay, depending on the service Individual therapy visit: • In-network: $25 copay • Out-of-network: $10-25 copay, depending on the service	Group therapy visit: • In-network: $10 copay • Out-of-network: $10-25 copay, depending on the service Individual therapy visit: • In-network: $25 copay • Out-of-network: $10-25 copay, depending on the service
Outpatient Surgery[1]	Ambulatory surgical center: • In-network: $225 copay • Out-of-network: $225 copay Outpatient hospital: • In-network: $225 copay • Out-of-network: $225 copay	Ambulatory surgical center: • In-network: $325 copay • Out-of-network: $325 copay Outpatient hospital: • In-network: $325 copay • Out-of-network: $325 copay
Over-the-Counter Items	Not Covered	Not Covered
Prosthetic Devices *(braces, artificial limbs, etc.)*[1]	Prosthetic devices: • In-network: 20% of the cost • Out-of-network: 20% of the cost Related medical supplies: • In-network: 20% of the cost • Out-of-network: 20% of the cost	Prosthetic devices: • In-network: 20% of the cost • Out-of-network: 20% of the cost Related medical supplies: • In-network: 20% of the cost • Out-of-network: 20% of the cost

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Renal Dialysis[1]	• In-network: 20% of the cost • Out-of-network: 20% of the cost	• In-network: 20% of the cost • Out-of-network: 20% of the cost
Transportation	Not covered	Not covered
Urgently Needed Services	• $25 copay If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for urgently needed services. See the "Inpatient Hospital Care" section of this booklet for other costs.	• $40 copay If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for urgently needed services. See the "Inpatient Hospital Care" section of this booklet for other costs.
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: $0-25 copay, depending on the service • Out-of-network: $25 copay Eyeglasses or contact lenses after cataract surgery: • In-network: $0 copay • Out-of-network: $0 copay	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: $0-40 copay, depending on the service • Out-of-network: $40 copay Eyeglasses or contact lenses after cataract surgery: • In-network: $0 copay • Out-of-network: $0 copay

Summary of Benefits

Benefit	Preferred Advantage Rx (PPO)	Preferred Complete Rx (PPO)
Preventive Care	In-network: You pay nothing Out-of-network: You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.	In-network: You pay nothing Out-of-network: You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonsocopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.

Summary of Benefits

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Hospice	• You pay nothing for hospice care from a Medicare-certified hospice. • You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.	• You pay nothing for hospice care from a Medicare-certified hospice. • You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.
INPATIENT CARE **Inpatient Hospital Care[1]**	Our plan covers an unlimited number of days for an inpatient hospital stay. • In-network: $200 copay per stay You pay nothing per day for days 91 and beyond • Out-of-network: $200 copay per stay	Our plan covers an unlimited number of days for an inpatient hospital stay. • In-network: $180 copay per day for days 1 through 9 You pay nothing per day for days 10 through 90 You pay nothing per day for days 91 and beyond • Out-of-network: $180 copay per day for days 1 through 9. You pay nothing per day for days 10 through 90
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.	For inpatient mental health care, see the "Mental Health Care" section of this booklet.
Skilled Nursing Facility (SNF)[1]	Our plan covers up to 100 days in a SNF. • In-network: You pay nothing per day for days 1 through 20 $160 copay per day for days 21 through 62 You pay nothing per day for days 63 through 100 • Out-of-network: You pay nothing per day for days 1 through 20 $160 copay per day for days 21 through 62 You pay nothing per day for days 63 through 100	Our plan covers up to 100 days in a SNF. • In-network: You pay nothing per day for days 1 through 20 $160 copay per day for days 21 through 62 You pay nothing per day for days 63 through 100 • Out-of-network: You pay nothing per day for days 1 through 20 $160 copay per day for days 21 through 62 You pay nothing per day for days 63 through 100

Summary of Benefits

Benefit	Preferred Advantage Rx (PPO)	Preferred Complete Rx (PPO)
PRESCRIPTION DRUG BENEFITS		
How much do I pay?	For Part B drugs such as chemotherapy drugs[1]: • In-network: 20% of the cost • Out-of-network: 20% of the cost Other Part B drugs[1]: • In-network: 20% of the cost • Out-of-network: 20% of the cost	For Part B drugs such as chemotherapy drugs[1]: • In-network: 20% of the cost • Out-of-network: 20% of the cost Other Part B drugs[1]: • In-network: 20% of the cost • Out-of-network: 20% of the cost
Initial Coverage	• You pay the following until your total yearly drug costs reach $3,310. • Total yearly drug costs are the total drug costs paid by both you and our Part D plan. • You may get your drugs at network retail pharmacies and mail order pharmacies.	• You pay the following until your total yearly drug costs reach $3,310. • Total yearly drug costs are the total drug costs paid by both you and our Part D plan. • You may get your drugs at network retail pharmacies and mail order pharmacies.

Standard Retail Cost-Sharing

Tier	One-month supply
Tier 1 (Preferred Generic)	$3 copay
Tier 2 (Generic)	$20 copay
Tier 3 (Preferred Brand)	$47 copay
Tier 4 (Non-Preferred Brand)	$100 copay
Tier 5 (Specialty Tier)	33% of the cost

Standard Retail Cost-Sharing

Tier	One-month supply
Tier 1 (Preferred Generic)	$3 copay
Tier 2 (Generic)	$20 copay
Tier 3 (Preferred Brand)	$47 copay
Tier 4 (Non-Preferred Brand)	$100 copay
Tier 5 (Specialty Tier)	33% of the cost

Summary of Benefits

Benefit	Preferred Advantage Rx (PPO)	Preferred Complete Rx (PPO)

Tier	Three month supply
Tier 1 (Preferred Generic)	$9 copay
Tier 2 (Generic)	$60 copay
Tier 3 (Preferred Brand)	$141 copay
Tier 4 (Non-Preferred Brand)	$300 copay
Tier 5 (Specialty Tier)	Not offered

Standard Mail Order Cost-Sharing

Tier	Three-month supply
Tier 1 (Preferred Generic)	$9 copay
Tier 2 (Generic)	$60 copay
Tier 3 (Preferred Brand)	$141 copay
Tier 4 (Non-Preferred Brand)	$300 copay

If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

Tier	Three month supply
Tier 1 (Preferred Generic)	$9 copay
Tier 2 (Generic)	$60 copay
Tier 3 (Preferred Brand)	$141 copay
Tier 4 (Non-Preferred Brand)	$300 copay
Tier 5 (Specialty Tier)	Not offered

Standard Mail Order Cost-Sharing

Tier	Three-month supply
Tier 1 (Preferred Generic)	$9 copay
Tier 2 (Generic)	$60 copay
Tier 3 (Preferred Brand)	$141 copay
Tier 4 (Non-Preferred Brand)	$300 copay

If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

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Coverage Gap	• Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,310. • After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 58% of the plan's cost for covered generic drugs until your costs total $4,850, which is the end of the coverage gap. Not everyone will enter the coverage gap. • Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you. **Standard Retail Cost-Sharing**	• Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,310. • After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 58% of the plan's cost for covered generic drugs until your costs total $4,850, which is the end of the coverage gap. Not everyone will enter the coverage gap. • Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you. **Standard Retail Cost-Sharing**

Tier	Drugs Covered
Tier 1 (Preferred Generic)	All

One month Supply	$3 copay
Three month supply	$9 copay

Tier	Drugs Covered
Tier 1 (Preferred Generic)	All

One month Supply	$3 copay
Three month supply	$9 copay

Summary of Benefits

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	Standard Mail Order Cost-Sharing **Tier** / **Drugs Covered** / **Three month supply** Tier 1 (Preferred Generic) / All / $9 copay	**Standard Mail Order Cost-Sharing** **Tier** / **Drugs Covered** / **Three month supply** Tier 1 (Preferred Generic) / All / $9 copay
Catastrophic Coverage	After your yearly out-of pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,850, you pay the greater of: • 5% of the cost, or • $2.95 copay for generic (inlcuding brand drugs treated as generic) and a $7.40 copayment for all other drugs.	After your yearly out-of pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,850, you pay the greater of: • 5% of the cost, or • $2.95 copay for generic (inlcuding brand drugs treated as generic) and a $7.40 copayment for all other drugs.
Optional Benefits (you must pay an extra premium each month for these benefits) **Package 1: Geisinger Gold Health+**	Benefits include: • Eligible Supplemental Benefits • Preventive Dental • Eye Exams • Eyewear • Hearing Exams • Hearing Aids	Benefits include: • Eligible Supplemental Benefits • Preventive Dental • Eye Exams • Eyewear • Hearing Exams • Hearing Aids
How much is the monthly premium?	• Additional $38 per month. • You must keep paying your Medicare Part B premium and your **Geisinger Gold Preferred Advantage Rx (PPO)** $69 monthly plan premium.	• Additional $38 per month. • You must keep paying your Medicare Part B premium and your **Geisinger Gold Preferred Complete Rx (PPO)** $0 monthly plan premium.
How much is the deductible?	This package does not have a deductible.	This package does not have a deductible.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit for certain benefits.	Our plan has a coverage limit for certain benefits.