Geisinger Gold Classic Complete Rx (HMO) offered by Geisinger Health Plan

Annual Notice of Changes for 2017

You are currently enrolled as a member of Geisinger Gold Classic Complete Rx (HMO). Next year, there will be some changes to the plan's costs and benefits. This booklet tells about the changes.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

Additional Resources

- Please contact our Member Services number at (800) 498-9731 for additional information. (TTY users should call 711. Hours are 8 a.m. to 8 p.m. seven days a week (October 1 through February 14) or Monday through Friday from 8 a.m. to 8 p.m. (February 15 through September 30).
- Member Services has free language interpreter services available for non-English speakers (phone numbers are in Section 7.1 of this booklet).
- This document may be available in alternate languages or formats. Contact Member Services for details.
- Minimum essential coverage (MEC): Coverage under this Plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information on the individual requirement for MEC.

About Geisinger Gold Classic Complete Rx (HMO)

- Geisinger Gold Medicare Advantage HMO plans are offered by Geisinger Health Plan, a health plan with a Medicare contract. Continued enrollment in Geisinger Gold depends on annual contract renewal.

- When this booklet says "we," "us," or "our," it means Geisinger Health Plan. When it says "plan" or "our plan," it means Geisinger Gold Classic Complete Rx (HMO).

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Think about Your Medicare Coverage for Next Year

Each fall, Medicare allows you to change your Medicare health and drug coverage during the Annual Enrollment Period. It's important to review your coverage now to make sure it will meet your needs next year.

Important things to do:

- ☐ **Check the changes to our benefits and costs to see if they affect you.** Do the changes affect the services you use? It is important to review benefit and cost changes to make sure they will work for you next year. Look in Section 1.5 for information about benefit and cost changes for our plan.
- ☐ **Check the changes to our prescription drug coverage to see if they affect you.** Will your drugs be covered? Are they in a different tier? Can you continue to use the same pharmacies? It is important to review the changes to make sure our drug coverage will work for you next year. Look in Section 1.6 for information about changes to our drug coverage.
- ☐ **Check to see if your doctors and other providers will be in our network next year.** Are your doctors in our network? What about the hospitals or other providers you use? Look in Section 1.3 for information about our Provider Directory.
- ☐ **Think about your overall health care costs.** How much will you spend out-of-pocket for the services and prescription drugs you use regularly? How much will you spend on your premium? How do the total costs compare to other Medicare coverage options?
- ☐ **Think about whether you are happy with our plan.**

If you decide to <u>stay</u> with Geisinger Gold Classic Complete Rx (HMO):

If you want to stay with us next year, it's easy - you don't need to do anything.

If you decide to <u>change</u> plans:

If you decide other coverage will better meet your needs, you can switch plans between October 15 and December 7. If you enroll in a new plan, your new coverage will begin on January 1, 2017. Look in Section 3.2 to learn more about your choices.

Summary of Important Costs for 2017

The table below compares the 2016 costs and 2017 costs for Geisinger Gold Classic Complete Rx (HMO) in several important areas. **Please note this is only a summary of changes**. **It is important to read the rest of this Annual Notice of Changes** and review the attached Evidence of Coverage to see if other benefit or cost changes affect you.

Cost	2016 (this year)	2017 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0	$0
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$5,900	$5,900
Doctor office visits	Primary care visits: $5 per visit Specialist visits: $30 per visit	Primary care visits: $5 per visit Specialist visits: $35 per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	$180 per day, days 1-9 $0 per day, days 10-90	$175 per day, days 1-5 $0 per day, days 6-90

Cost	2016 (this year)	2017 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Costs during the Initial Coverage Stage: • Tier 1 (Preferred Generic Drugs): $3 copay for one-month (30-day) supply; $9 copay for three-month (90-day) supply at a retail pharmacy • Tier 2 (Generic Drugs): $20 copay for one-month (30-day) supply; $60 copay for three-month (90-day) supply at a retail pharmacy • Tier 3 (Preferred Brand Drugs): $47 copay for one-month (30-day) supply; $141 copay for three-month (90-day) supply at a retail pharmacy • Tier 4 (Non-Preferred Brand Drugs): $100 copay for one-month (30-day) supply; $300 copay for three-month (90-day) supply at a retail pharmacy • Tier 5 (Specialty Drugs): 33% coinsurance for one-month (30-day) supply	Deductible: $0 Costs during the Initial Coverage Stage: • Tier 1 (Preferred Generic Drugs): $3 copay for one-month (30-day) supply; $7.50 copay for three-month (90-day) supply at a retail pharmacy • Tier 2 (Generic Drugs): $20 copay for one-month (30-day) supply; $50 copay for three-month (90-day) supply at a retail pharmacy • Tier 3 (Preferred Brand Drugs): $47 copay for one-month (30-day) supply; $117.50 copay for three-month (90-day) supply at a retail pharmacy • Tier 4 (Non-Preferred Brand Drugs): $100 copay for one-month (30-day) supply; $250 copay for three-month (90-day) supply at a retail pharmacy • Tier 5 (Specialty Drugs): 33% coinsurance for one-month (30-day) supply

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2016 (this year)	2017 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0
Health+ Optional Supplemental Benefits For members enrolled in this optional package, an additional monthly premium applies	$38	$38

- Your monthly plan premium will be more if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be less if you are receiving "Extra Help" with your prescription drug costs.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2016 (this year)	2017 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium does not count toward your maximum out-of-pocket amount.	$5,900	$5,900 Once you have paid $5,900 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at www.GeisingerGold.com. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2017 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- When possible we will provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.

- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan please contact us so we can assist you in finding a new provider and managing your care.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at www.GeisingerGold.com. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2017 Pharmacy Directory to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, Medical Benefits Chart (what is covered and what you pay), in your 2017 Evidence of Coverage.

Cost	2016 (this year)	2017 (next year)
Specialist Office Visit	You pay a $30 copay per visit	You pay a $35 copay per visit
Inpatient Hospital	You pay the following copays: $180 per day, days 1-9 $0 per day, days 6-90	You pay the following copays: $175 per day, days 1-5 $0 per day, days 6-90
Inpatient Psychiatric Hospital	You pay the following copays: $170 per day, days 1-9 $0 per day, days 6-90	You pay the following copays: $175 per day, days 1-5 $0 per day, days 6-90
Urgently Needed Services	You pay a $30 copay (waived if admitted)	You pay a $35 copay (waived if admitted)

Cost	2016 (this year)	2017 (next year)
Podiatry (Original Medicare Benefits)	You pay a $30 copay	You pay a $35 copay
Occupational Therapy	You pay a $30 copay per day	You pay a $35 copay per day
Physical & Speech Therapy	You pay a $30 copay per day	You pay a $35 copay per day
Outpatient Hospital/Ambulatory Surgery Services	You pay a $300 copay	You pay a $265 copay
Ambulance	You pay a $175 copay (waived if admitted)	You pay a $200 copay (waived if admitted)
Medicare Covered Comprehensive Dental Exam	You pay a $30 copay	You pay a $35 copay
Medicare Covered Vision Exam	You pay a $30 copay	You pay a $35 copay
Diagnostic Hearing Exam	You pay a $30 copay	You pay a $35 copay
Health+ Optional Supplemental Benefit: Dental	1 routine exam every 6 months (with or without cleaning); 1 set of x-rays per year (bitewing & panoramic); $250 max benefit per year; see any provider	2 routine exams per year (with or without cleaning), 1 set of x-rays per year (bitewing & panoramic), simple fillings, simple extractions, dentures; $500 max benefit per year; see any provider
Health+ Optional Supplemental Benefit: Hearing	$20 copay for 1 routine exam per year; $250 hearing aid allowance per year; see any provider	$20 copay for 1 routine exam per year; $500 hearing aid allowance per year; see any provider

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is in this envelope.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug.
    - To learn what you must do to ask for an exception, see Chapter 9 of your Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) or call Member Services.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a **one-time**, temporary supply of a non-formulary drug in the first 90 days of coverage of the plan year or coverage. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the Evidence of Coverage.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

If you were approved for a formulary exception in 2016, unless otherwise noted in your Notice of Approval of Medical Coverage letter, a new formulary exception will not be needed for 2017 as long as you remain a member of the same plan.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you get "Extra Help" and haven't received this insert by September 30, 2016, please call Member Services and ask for the "LIS Rider." Phone numbers for Member Services are in Section 7.1 of this booklet.

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your Evidence of Coverage for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the attached Evidence of Coverage.)

Changes to the Deductible Stage

Stage	2016 (this year)	2017 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost-sharing in the Initial Coverage Stage

Please see the following chart for the changes from 2016 to 2017.

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, Types of out-of-pocket costs you may pay for covered drugs in your Evidence of Coverage.

Stage	2016 (this year)	2017 (next year)
Stage 2: Initial Coverage Stage The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your Evidence of Coverage.	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: • Tier 1 (Preferred Generic Drugs): You pay $3 copay per prescription • Tier 2 (Generic Drugs): You pay $20 copay per prescription	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: • Tier 1 (Preferred Generic Drugs): You pay $3 copay per prescription • Tier 2 (Generic Drugs): You pay $20 copay per prescription

We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	• Tier 3 (Preferred Brand Drugs): You pay $47 copay per prescription • Tier 4 (Non-Preferred Brand Drugs): You pay $100 copay per prescription • Tier 5 (Specialty Drugs): You pay 33% coinsurance per prescription Once your total drug costs have reached $3,310 you will move to the next stage (the Coverage Gap Stage).	• Tier 3 (Preferred Brand Drugs): You pay $47 copay per prescription • Tier 4 (Non-Preferred Brand Drugs): You pay $100 copay per prescription • Tier 5 (Specialty Drugs): You pay 33% coinsurance per prescription Once your total drug costs have reached $3,700 you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your Evidence of Coverage.

SECTION 2 Other Changes

	2016 (this year)	2017 (next year)
Beginning January 1, 2017, Geisinger Gold Classic Complete Rx (HMO) will not require PCP referrals for specialty care. Members are still required to use network providers for covered services.	Referrals required	Referrals not required

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Geisinger Gold Classic Complete Rx (HMO)

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2017.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2017 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- -- OR-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan and whether to buy a Medicare supplement (Medigap) policy.

To learn more about Original Medicare and the different types of Medicare plans, read Medicare & You 2017, call your State Health Insurance Assistance Program (SHIP) (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to http://www.medicare.gov and click "Review and Compare Your Coverage Options." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Geisinger Gold Classic Complete Rx (HMO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Geisinger Gold Classic Complete Rx (HMO).
- To **change to Original Medicare without a prescription drug plan,** you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
    - – or – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2017.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area are allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the Evidence of Coverage.

If you enrolled in a Medicare Advantage plan for January 1, 2017, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2017. For more information, see Chapter 10, Section 2.2 of the Evidence of Coverage.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Pennsylvania, the SHIP is called Apprise.

Apprise is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Apprise counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Apprise at 1-800-783-7067.

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or

- Your State Medicaid Office (applications).

- **Help from your state's pharmaceutical assistance program.** Pennsylvania has a program called PACE that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Section 5 of this booklet).

- **What if you have coverage from an AIDS Drug Assistance Program (ADAP)?** The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the Special Pharmaceutical Benefits Program, (SPBP) customer service at 1-800-922-9384. Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. For information please call the SPBP customer service at 1-800-922-9384.

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the SPBP customer service at 1-800-922-9384 or send questions to SPBP@pa.gov.

SECTION 7 Questions?

Section 7.1 – Getting Help from Geisinger Gold Classic Complete Rx (HMO)

Questions? We're here to help. Please call Member Services at (800) 498-9731 (TTY only, call 711). We are available for phone calls seven days a week from 8 a.m. to 8 p.m. (October 1 through February 14) or Monday through Friday from 8 a.m. to 8 p.m. (February 15 through September 30). Calls to these numbers are free.

Read your 2017 Evidence of Coverage (it has details about next year's benefits and costs)

This Annual Notice of Changes gives you a summary of changes in your benefits and costs for 2017. For details, look in the 2017 Evidence of Coverage for Geisinger Gold Classic Complete Rx (HMO). The Evidence of Coverage is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the Evidence of Coverage is included in this envelope.

Visit Our Website

You can also visit our website at www.GeisingerGold.com. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (http://www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to http://www.medicare.gov and click on “Find health & drug plans”)

Read Medicare & You 2017

You can read Medicare & You 2017 Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don’t have a copy of this booklet, you can get it at the Medicare website (http://www.medicare.gov) or 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.