

Geisinger

EVIDENCE OF COVERAGE 2023

Geisinger Gold Secure Rx (HMO D-SNP)

**Geisinger Gold
Member Services
1-800-498-9731
Toll-Free**

**October 1 – March 31
8am – 8pm 7 days a week**

**April 1 – September 30
8am – 8pm Monday – Friday
8am – 2pm Saturday**

January 1 – December 31, 2023

Evidence of Coverage:

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Geisinger Gold Secure Rx (HMO D-SNP)

This document gives you the details about your Medicare health care and prescription drug coverage from January 1 – December 31, 2023. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact Member Services at 1-800-498-9731 or Pharmacy Member Services at 1-800-988-4861. (TTY users should call PA Relay: 711 or 1-800-654-5984). Hours are

October 1- March 31:	8 a.m. to 8 p.m. 7 days a week
April 1- September 30:	8 a.m. to 8 p.m. Monday-Friday; 8 a.m. to 2 p.m. Saturday

This plan, Geisinger Gold Secure Rx (HMO D-SNP), is offered by Geisinger Health Plan (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means Geisinger Health Plan. When it says “plan” or “our plan,” it means Geisinger Gold Secure Rx (HMO D-SNP).

We can also give you plan information in braille, in audio, in large print, or other alternate formats if you need it. Member Services has free language interpreter services available for non-English speakers.

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2024.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

This document explains your benefits and rights. Use this document to understand about:

- Your plan premium and cost sharing;
- Your medical and prescription drug benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

Geisinger Gold Secure Rx (HMO D-SNP) has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until December 31, 2023, based on a review of Geisinger Gold Secure Rx (HMO D-SNP)'s Model of Care.

2023 Evidence of Coverage

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CHAPTER 1:

Getting started as a member

SECTION 1 Introduction

Section 1.1	You are enrolled in Geisinger Gold Secure Rx (HMO D-SNP), which is a specialized Medicare Advantage Plan (Special Needs Plan)
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You are covered by both Medicare and Pennsylvania Medical Assistance (Medicaid):

- **Medicare** is the Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (kidney failure).
- **Pennsylvania Medical Assistance (Medicaid)** is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Pennsylvania Medical Assistance (Medicaid) coverage varies depending on the state and the type of Pennsylvania Medical Assistance (Medicaid) you have. Some people with Pennsylvania Medical Assistance (Medicaid) get help paying for their Medicare premiums and other costs. Other people also get coverage for additional services and drugs that are not covered by Medicare.

You have chosen to get your Medicare health care and your prescription drug coverage through our plan, Geisinger Gold Secure Rx (HMO D-SNP). We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

Geisinger Gold Secure Rx (HMO D-SNP) is a specialized Medicare Advantage Plan (a Medicare “Special Needs Plan”), which means its benefits are designed for people with special health care needs. Geisinger Gold Secure Rx (HMO D-SNP) is designed for people who have Medicare and who are also entitled to assistance from Pennsylvania Medical Assistance (Medicaid).

Because you get assistance from Pennsylvania Medical Assistance (Medicaid) with your Medicare Part A and B cost sharing (deductibles, copayments, and coinsurance) you may pay nothing for your Medicare health care services. Pennsylvania Medical Assistance (Medicaid) may also provide other benefits to you by covering health care services, prescription drugs, long-term care and/or home and community-based services that are not usually covered under Medicare. You will also receive “Extra Help” from Medicare to pay for the costs of your Medicare prescription drugs. Geisinger Gold Secure Rx (HMO D-SNP) will help manage all of these benefits for you, so that you get the health care services and payment assistance that you are entitled to.

Geisinger Gold Secure Rx (HMO D-SNP) is run by a non-profit organization. Like all Medicare Advantage Plans, this Medicare Special Needs Plan is approved by Medicare. The plan also has a contract with the Pennsylvania Medical Assistance (Medicaid) program to coordinate your Pennsylvania Medical Assistance (Medicaid) benefits. We are pleased to be providing your Medicare health care coverage, including your prescription drug coverage.

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Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

Section 1.2 What is the *Evidence of Coverage* document about?

This *Evidence of Coverage* document tells you how to get your Medicare medical care and prescription drugs. It explains your rights and responsibilities, what is covered, what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

The words “coverage” and “covered services” refers to the medical care and services and the prescription drugs available to you as a member of Geisinger Gold Secure Rx (HMO D-SNP).

It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* document.

If you are confused, concerned or just have a question, please contact Member Services.

Section 1.3 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how Geisinger Gold Secure Rx (HMO D-SNP) covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called “riders” or “amendments.”

The contract is in effect for months in which you are enrolled in Geisinger Gold Secure Rx (HMO D-SNP) between January 1, 2023 and December 31, 2023.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Geisinger Gold Secure Rx (HMO D-SNP) after December 31, 2023. We can also choose to stop offering the plan in your service area, or to offer it in a different service area, after December 31, 2023.

Medicare (the Centers for Medicare & Medicaid Services) must approve Geisinger Gold Secure Rx (HMO D-SNP) each year. You can continue each year to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1	Your eligibility requirements
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You are eligible for membership in our plan as long as:

- You have both Medicare Part A and Medicare Part B
- -- *and* -- You live in our geographic service area (Section 2.3 below describes our service area).
- Incarcerated (in jail) individuals are not considered living in the geographic service area even if they are physically located in it.
- -- *and* -- you are a United States citizen or are lawfully present in the United States
- -- *and* -- You meet the special eligibility requirements described below.

Special eligibility requirements for our plan

Our plan is designed to meet the needs of people who receive certain Pennsylvania Medical Assistance (Medicaid) benefits. (Pennsylvania Medical Assistance (Medicaid) is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan you must be eligible for Medicare and Full Pennsylvania Medical Assistance (Medicaid) Benefits.

Please note: If you lose your Pennsylvania Medical Assistance (Medicaid) eligibility but can reasonably be expected to regain eligibility within six (6) months, then you are still eligible for membership in our plan (Chapter 4, Section 2.1 tells you about coverage and cost sharing during a period of deemed continued eligibility).

Section 2.2	What is Pennsylvania Medical Assistance (Medicaid)?
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Pennsylvania Medical Assistance (Medicaid) is a joint Federal and state government program that helps with medical and long-term care costs for certain people who have limited incomes and resources. Each state decides what counts as income and resources, who is eligible, what services are covered, and the cost for services. States also can decide how to run their program as long as they follow the Federal guidelines.

In addition, there are programs offered through Pennsylvania Medical Assistance (Medicaid) that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These “Medicare Savings Programs” help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB)+:** An individual who meets the standards for QMB eligibility, and who also meets the criteria for full Medicaid benefits. Pennsylvania Medical Assistance (Medicaid) pays their Medicare Part A premiums, if any, Medicare

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Part B premiums, Medicare deductibles and coinsurance, and provides full Pennsylvania Medical Assistance (Medicaid) benefits to the extent consistent with the State Plan.

- **SLMB+:** An individual who meets the standards for SLMB eligibility, and who also meets the criteria for full State Medicaid benefits. These individuals are entitled to payment of the Medicare Part B premium, in addition to full State Medicaid benefits.
- **Full Benefit Dual Eligible (FBDE):** Eligible for Medicaid either categorically or through optional coverage groups. However, Medicaid does not pay toward out-of-pocket costs.

Geisinger Gold Secure Rx (HMO D-SNP) members, who are eligible for both Medicare and Pennsylvania Medical Assistance (Medicaid), are required to select a Community HealthChoices (CHC) Plan to administer the Pennsylvania Medical Assistance (Medicaid) portion only of their health care coverage.

For questions about your Pennsylvania Medical Assistance (Medicaid) benefits, contact the PA CHC Helpline at 1-844-824-3655 (TTY: 1-833-254-0690) or your Community HealthChoices (CHC) Plan at:

CHC Plan	Website	Call	TTY
AmeriHealth Caritas Pennsylvania	http://www.amerihealthcaritaschc.com	1-855-235-5115	1-855-235-5112
Keystone First Community HealthChoices	http://www.keystonefirstchc.com	1-855-332-0729	1-855-235-4976
PA Health & Wellness	https://www.pahealthwellness.com	1-844-626-6813	1-844-349-8916
UPMC Community HealthChoices	https://www.upmchealthplan.com/chc	1-844-833-0523	1-866-407-8762

<p>Section 2.3 Here is the plan service area for Geisinger Gold Secure Rx (HMO D-SNP)</p>
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Geisinger Gold Secure Rx (HMO D-SNP) is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these counties in Pennsylvania:

Adams**Centre****Franklin****McKean****Somerset**

Chapter 1 Getting started as a member

Armstrong	Chester	Fulton	Mifflin	Sullivan
Beaver	Clarion	Greene	Monroe	Susquehanna
Bedford	Clearfield	Huntingdon	Montour	Tioga
Berks	Clinton	Jefferson	Northampton	Union
Blair	Columbia	Juniata	Northumberland	Venango
Bradford	Crawford	Lackawanna	Perry	Warren
Bucks	Cumberland	Lancaster	Philadelphia	Washington
Butler	Dauphin	Lebanon	Pike	Wayne
Cambria	Delaware	Lehigh	Potter	Westmoreland
Cameron	Elk	Luzerne	Schuylkill	Wyoming
Carbon	Forest	Lycoming	Snyder	York

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Member Services to see if we have a plan in your new area. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Section 2.4	U.S. Citizen or Lawful Presence
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A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Geisinger Gold Secure Rx (HMO D-SNP) if you are not eligible to remain a member on this basis. Geisinger Gold Secure Rx (HMO D-SNP) must disenroll you if you do not meet this requirement.

SECTION 3 Important Membership Materials You Will Receive

Section 3.1 Your plan membership card

While you are a member of our plan, you must use your membership card whenever you get services covered by this plan and for prescription drugs you get at network pharmacies. You should also show the provider your Pennsylvania Medical Assistance (Medicaid) card. Here's a sample membership card to show you what yours will look like:

	First Name Last Name ID 12345678901 Medical record # 12345678
PCP copay \$XX	Primary care XXXX
Spec coinsurance \$XXX	Office XXXXXXXXXXXXXXXXX 123/456-7891
ER copay \$XXX	Rx BIN 019587 PCN PRX11803
MOOP* \$XXXX	Formulary X
<small>Offered by Geisinger Health Plan, part of Geisinger.</small>	
 Prescription Drug Coverage X	
Gold Secure Rx (HMO D-SNP) <small>A Medicare Advantage Plan</small>	

Connect with us	GeisingerHealthPlan.com
Customer service 800-498-9731	Mail medical claims to Geisinger Health Plan PO Box 853910, Richardson, TX 75085-3910
Prescription questions 800-988-4861	Mail dental claims to SKYGEN PO Box 512, Milwaukee, WI 53201
Tel-A-Nurse 877-543-5061	Mail general information to Geisinger Health Plan, 100 N. Academy Ave. Danville, PA 17822-3229
TTY hearing impaired PA Relay at 711	Pharmacy technical assistance 1-855-508-1715
Emergency 911	Dental provider assistance 877-378-5292
Mental health / Substance abuse 888-839-7972	<small>Issuer: 80840 Issue date 01/01/2019 XX-XX CMS HXXXX - XXX</small>
* Maximum Out-Of-Pocket	

Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your Geisinger Gold Secure Rx (HMO D-SNP) membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare approved clinical research studies also called clinical trials.

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

Section 3.2 The Provider Directory: Your guide to all providers and pharmacies in the plan's network

The *Provider Directory* lists our network providers, network pharmacies and durable medical equipment suppliers. **Network providers** are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full. Our Provider Directory also gives you a complete list of our **network pharmacies** – that means all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

The directory also includes Geisinger Gold network providers. Please note that not all providers are currently accepting Pennsylvania Medical Assistance (Medicaid) patients. Before receiving services, members should contact the provider's office to confirm that the provider is currently

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accepting both Pennsylvania Medical Assistance (Medicaid) and Geisinger Gold Secure Rx (HMO D-SNP).

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization you will have to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it is unreasonable or not possible to obtain services in-network), out-of-area dialysis services, and cases in which Geisinger Gold Secure Rx (HMO D-SNP) authorizes use of out-of-network providers.

You must use network pharmacies to get your prescriptions filled or refilled. The provider directory lists our network pharmacies. **Network pharmacies** are all of the pharmacies that have agreed to fill covered prescriptions for our plan members. You can use the *Provider Directory* to find the network pharmacy you want to use. See Chapter 5, Section 2.5 for information on when you can use pharmacies that are not in the plan's network.

If you don't have your copy of the *Provider Directory*, you can request a copy from Member Services. The most recent list of providers, pharmacies and suppliers is available on our website at www.GeisingerGold.com.

IMPORTANT: Your Pennsylvania Medical Assistance (Medicaid) benefits will cover your Medicare cost sharing as long as you follow the plans' rules for getting your care and meet the coverage requirements for Medicare cost sharing assistance under Pennsylvania Medical Assistance (Medicaid). To receive this Pennsylvania Medical Assistance (Medicaid) coverage of your Medicare coinsurance or copayments, you must obtain your care from a Geisinger Gold network provider who also accept Pennsylvania Medical Assistance (Medicaid).

Section 3.2.1 Hepatitis C Treatment at a Center of Excellence (COE)

Members with Hepatitis C are encouraged to visit a Center of Excellence for treatment. A COE is a group of licensed physicians who share a hospital or medical center in order to provide high quality specialty healthcare for chronic conditions. Physicians located in the COE demonstrate best practices by using clinically proven health care management techniques as evidenced by their exceptional cure rates following treatment, high adherence rates for medication and excellent patient satisfaction scores. Geisinger Gold currently has four COE facilities that focus on treatment of Hepatitis C. Hepatitis C viral infection can be a chronic condition where scarring can damage the liver over time. Questions may be directed to the Pharmacy Customer Service Team at 800-988-4861.

Section 3.3 The plan's List of Covered Drugs (*Formulary*)

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered under the Part D benefit included in Geisinger Gold Secure Rx (HMO D-SNP). The drugs on this list are selected by the plan with the help of a team

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of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the Geisinger Gold Secure Rx (HMO D-SNP) Drug List. In addition to the drugs covered by Part D, some prescription drugs are covered for you under your Pennsylvania Medical Assistance (Medicaid) benefits. The Drug List tells you how to find out which drugs are covered under Pennsylvania Medical Assistance (Medicaid).

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We will provide you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan's website (www.GeisingerGold.com) or call Pharmacy Member Services.

SECTION 4 Your monthly costs for Geisinger Gold Secure Rx (HMO D-SNP)

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Part D Late Enrollment Penalty (Section 4.3)
- Income Related Monthly Adjusted Amount (Section 4.4)

In some situations, your plan premium could be less

If you are *already enrolled* and getting help from one of these programs, **the information about premiums in this *Evidence of Coverage* 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 known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don't have this insert, please call Member Services and ask for the “LIS Rider.”

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums review your copy of *Medicare & You 2023* handbook, the section called “2023 Medicare Costs.” If you need a copy you can download it from the Medicare website (www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.1	Plan premium
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Your plan has a Medicare Part D prescription Drug Plan premium that is paid on behalf of members by Medicare Part D “Extra Help”.

You do not pay a separate monthly plan premium for Geisinger Gold Secure Rx (HMO D-SNP).

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

Some members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must maintain your eligibility for Pennsylvania Medical Assistance (Medicaid) as well as have both Medicare Part A and Medicare Part B. For most Geisinger Gold Secure Rx (HMO D-SNP) members, Pennsylvania Medical Assistance (Medicaid) pays for your Part A premium (if you don't qualify for it automatically) and for your Part B premium.

If Pennsylvania Medical Assistance (Medicaid) is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan. This includes your premium for Part B. It may also include a premium for Part A which affects members who aren't eligible for premium free Part A.

Section 4.3 Part D Late Enrollment Penalty

Some members are required to pay a Part D **late enrollment penalty (LEP)**. Because you are dual-eligible, the LEP doesn't apply as long as you maintain your dual-eligible status, but if you lose status, you may incur LEP. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. "Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

When you first enroll in Geisinger Gold Secure Rx (HMO D-SNP), we let you know the amount of the penalty.

You **will not** have to pay it if:

- You receive "Extra Help" from Medicare to pay for your prescription drugs.
- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.

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- **Note:** Any notice must state that you had “creditable” prescription drug coverage that is expected to pay as much as Medicare’s standard prescription drug plan pays.
- **Note:** The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

Medicare determines the amount of the penalty. Here is how it works:

- First, count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2023, this average premium amount is \$32.74.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be 14% times \$32.74, which equals \$4.5836. This rounds to \$4.58. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty.**

There are three important things to note about this monthly Part D late enrollment penalty:

- First, **the penalty may change each year**, because the average monthly premium can change each year.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don’t have coverage after your initial enrollment period for aging into Medicare.

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review. Generally, you must request this review **within 60 days** from the date on the first letter you receive stating you have to pay a late enrollment penalty. However, if you were paying a penalty before joining our plan, you may not have another chance to request a review of that late enrollment penalty.

Section 4.4 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit <https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans>.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. **You must pay the extra amount to the government. It cannot be paid with your monthly plan premium. If you do not pay the extra amount you will be disenrolled from the plan and lose prescription drug coverage.**

If you disagree about paying an extra amount, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

SECTION 5 More information about your monthly premium

Section 5.1 If you pay a Part D late enrollment penalty, there are several ways you can pay your plan premium

There are four ways you can pay your penalty.

Option 1: Paying by check

You may decide to pay your monthly Part D late enrollment penalty by check. You will receive a statement with payment instructions in the mail each month from our billing office. Your Part D late enrollment penalty is due to Geisinger Health Plan by the 1st day of each month for that month's plan coverage. If you lose your statement or have questions about paying your premium, please call Member Services.

Checks should be made payable to Geisinger Health Plan. For your convenience, a payment slip and window envelope is included each month with your statement. Payments should be mailed to Geisinger Health Plan, P. O. Box 829703, Philadelphia, PA, 19182-9703. Checks should be received by Geisinger Health Plan on or before the 1st day of each coverage month.

Option 2: You may have your monthly Part D late enrollment penalty charged directly to your credit card or debit card

You will receive a statement with payment instructions in the mail each month from our billing office. To pay by credit card or debit card, register at www.GeisingerGold.com to use our online bill payment service.

Option 3: Having your Part D late enrollment penalty taken out of your monthly Social Security check

You can have Part D late enrollment penalty taken out of your monthly Social Security check. Contact Member Services for more information on how to pay your penalty this way. We will be happy to help you set this up.

Option 4: You can have your monthly Part D late enrollment penalty automatically withdrawn from your bank account.

You can have the monthly Part D late enrollment penalty automatically withdrawn from your bank account by electronic funds transfer. If you choose to pay your monthly Part D late enrollment penalty by automatic withdrawal from your bank account, your payment will be deducted from your bank account the 1st calendar day of each month. If this date falls on a weekend or holiday, your automatic payment will be withdrawn on the next business day. To set up monthly payments by automatic withdrawal, please call Member Services or register at www.GeisingerGold.com to use our online bill payment service.

Changing the way you pay your Part D late enrollment penalty. If you decide to change the way you pay your Part D late enrollment penalty, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your Part D late enrollment penalty is paid on time. To change your payment method, you can have your Part D late enrollment penalty taken out of your monthly Social Security check. Contact Member Services for more information on how to pay your penalty this way. We will be happy to help you set this up.

What to do if you are having trouble paying your Part D late enrollment penalty

If you are required to pay a Part D late enrollment penalty that penalty is due in our office by the 1st day of the month. If we have not received your Part D late enrollment penalty by the 1st day of the month, we will send you a monthly invoice of the penalty amount that are due to help you keep your account up to date.

If you are having trouble paying your Part D late enrollment penalty on time, please contact Member Services to see if we can direct you to programs that will help with your penalty.

Section 5.2 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan’s monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in September and the change will take effect on January 1.

However, in some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for the “Extra Help” program or if you lose your eligibility for the “Extra Help” program during the year. If a member qualifies for “Extra Help” with their prescription drug costs, the “Extra Help” program will pay part of the member’s monthly plan premium. A member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about the “Extra Help” program in Chapter 2, Section 7.

However, in some cases, you may be able to stop paying a late enrollment penalty, if owed. Or need to start paying a late enrollment penalty. (This could happen if you become eligible for the “Extra Help” program or if you lose your eligibility for the “Extra Help” program during the year:

- If you currently pay the Part D late enrollment penalty and become eligible for “Extra Help” during the year, you would be able to stop paying your penalty.
- If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

You can find out more about the “Extra Help” program in Chapter 2, Section 7.

SECTION 6 Keeping your plan membership record up to date

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage including your Primary Care Provider.

The doctors, hospitals, pharmacists, and other providers in the plan’s network need to have correct information about you. **These network providers use your membership record to know what services and drugs are covered and the cost-sharing amounts for you.** Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse’s employer, workers’ compensation, or Pennsylvania Medical Assistance (Medicaid))
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home

Chapter 1 Getting started as a member

- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study (**Note:** You are not required to tell your plan about the clinical research studies you intend to participate in but we encourage you to do so).

If any of this information changes, please let us know by calling Member Services. You may also send us a secure email telling us about changes to your membership record by visiting the member website at www.geisinger.org and scrolling down to the section called "Health Plan shoppers & members" clicking on "Sign in to your account" near the center of the webpage. Click on "Send secure message" in the first line in the white area. Complete the form giving as much detail as possible. Click on Submit.

Registered website users may also access claims records, request replacement ID cards, change their PCP and more. Haven't registered for access to the secure section of the website yet? Registration is easy; you will need your ID card and your email address to register. Visit www.geisinger.org, and scroll down to the section for Health Plan shoppers & members to "Sign into your account" and click on that link. Click the button that shows "Create account". Click on the link that shows "Member" and follow the step-by-step instructions. If you have questions about accessing the secure Member section of our website, please call Member Services.

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

SECTION 7 How other insurance works with our plan

Other insurance

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. This is called **Coordination of Benefits**.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Services. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs. If you have other insurance, tell your doctor, hospital, and pharmacy.

Chapter 1 Getting started as a member

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Pennsylvania Medical Assistance (Medicaid) and TRICARE never pay first for Medicare-covered services. They only pay after Medicare and/or employer group health plans have paid.

CHAPTER 2:

*Important phone numbers
and resources*

SECTION 1 Geisinger Gold Secure Rx (HMO D-SNP) contacts (how to contact us, including how to reach Member Services)

How to contact our plan's Member Services

For assistance with claims, billing, or membership card questions, please call or write to Geisinger Gold Secure Rx (HMO D-SNP) Member Services. We will be happy to help you.

Method	Member Services – Contact Information
CALL	<p>1-800-498-9731 Calls to this number are free.</p> <p>Our business hours: October 1- March 31: 8 a.m. to 8 p.m. 7 days a week April 1- September 30: 8 a.m. to 8 p.m. Monday-Friday; 8 a.m. to 2 p.m. Saturday</p> <p>After hours, an automated voice messaging service is available. If you leave a message, please include your name, phone number and the time you called. A Customer Service Representative will return your call within one business day.</p> <p>Member Services also has free language interpreter services available for non-English speakers</p>
TTY	<p>TTY users call PA Relay: 711 or 1-800-654-5984 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.</p> <p>Our business hours: October 1- March 31: 8 a.m. to 8 p.m. 7 days a week April 1- September 30: 8 a.m. to 8 p.m. Monday-Friday; 8 a.m. to 2 p.m. Saturday</p>
FAX	570-271-5871
WRITE	Geisinger Gold 100 North Academy Avenue Danville, PA 17822-2580
WEBSITE	www.GeisingerGold.com

How to contact our plan's Pharmacy Member Services

For assistance with coverage for your Part D drugs, please call or write to Geisinger Gold Secure Rx (HMO D-SNP) Pharmacy Member Services. We will be happy to help you.

Method	Pharmacy Member Services – Contact Information
CALL	<p>1-800-988-4861 Calls to this number are free.</p> <p>Our business hours: October 1- March 31: 8 a.m. to 8 p.m. 7 days a week April 1- September 30: 8 a.m. to 8 p.m. Monday-Friday; 8 a.m. to 2 p.m. Saturday</p> <p>After hours, an automated voice messaging service is available. If you leave a message, please include your name, phone number and the time you called. A Customer Service Representative will return your call within one business day.</p> <p>Member Services also has free language interpreter services available for non-English speakers</p>
TTY	<p>TTY users call PA Relay: 711 or 1-800-654-5984 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.</p> <p>Our business hours: October 1- March 31: 8 a.m. to 8 p.m. 7 days a week April 1- September 30: 8 a.m. to 8 p.m. Monday-Friday; 8 a.m. to 2 p.m. Saturday</p>
FAX	570-300-2122
WRITE	Geisinger Gold Pharmacy Department 100 North Academy Avenue Danville, PA 17822-2580
WEBSITE	www.GeisingerGold.com

Chapter 2 Important phone numbers and resources**How to contact us when you are asking for a coverage decision or appeal about your medical care**

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or Part D prescription drugs. An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on asking for coverage decisions or appeals about your medical care or Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Coverage Decisions for Medical Care – Contact Information
CALL	1-800-544-3907 Calls to this number are Hours are 8:00 a.m. to 5:00 p.m. Monday through Friday. Voicemail is available during non-business hours.
TTY	TTY users call PA Relay: 711 or 1-800-654-5984 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are 8:00 a.m. to 5:00 p.m. Monday through Friday.
FAX	570-271-5534
WRITE	Medical Management Department Geisinger Health Plan 100 North Academy Avenue Danville, PA 17822-3218
WEBSITE	www.GeisingerGold.com

Chapter 2 Important phone numbers and resources

Method	Coverage Decisions for Part D prescription drugs – Contact Information
CALL	<p>1-800-988-4861 Calls to this number are</p> <p>Our business hours: October 1- March 31: 8 a.m. to 8 p.m. 7 days a week April 1- September 30: 8 a.m. to 8 p.m. Monday-Friday; 8 a.m. to 2 p.m. Saturday</p> <p>After hours, an automated voice messaging service is available. If you leave a message, please include your name, phone number and the time you called. A Customer Service Representative will return your call within one business day.</p>
TTY	<p>TTY users call PA Relay: 711 or 1-800-654-5984 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.</p> <p>Our business hours: October 1- March 31: 8 a.m. to 8 p.m. 7 days a week April 1- September 30: 8 a.m. to 8 p.m. Monday-Friday; 8 a.m. to 2 p.m. Saturday</p>
FAX	570-300-2122
WRITE	Geisinger Gold Pharmacy Department 100 North Academy Avenue Danville, PA 17822-2410
WEBSITE	www.GeisingerGold.com

Chapter 2 Important phone numbers and resources

Method	Appeals for Medical Care – Contact Information
CALL	<p>1-800-498-9731 Calls to this number are</p> <p>Our business hours: October 1- March 31: 8 a.m. to 8 p.m. 7 days a week April 1- September 30: 8 a.m. to 8 p.m. Monday-Friday; 8 a.m. to 2 p.m. Saturday</p> <p>After hours, an automated voice messaging service is available. If you leave a message, please include your name, phone number and the time you called. A Customer Service Representative will return your call within one business day.</p>
TTY	<p>TTY users call PA Relay: 711 or 1-800-654-5984 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.</p> <p>Our business hours: October 1- March 31: 8 a.m. to 8 p.m. 7 days a week April 1- September 30: 8 a.m. to 8 p.m. Monday-Friday; 8 a.m. to 2 p.m. Saturday</p>
FAX	570-271-7225 Attention: Member Resolution Team
WRITE	Geisinger Gold Member Resolution Team 100 North Academy Avenue Danville, PA 17822-3220
WEBSITE	www.GeisingerGold.com

Chapter 2 Important phone numbers and resources

Method	Appeals for Part D prescription drugs – Contact Information
CALL	<p>1-800-988-4861 Calls to this number are</p> <p>Our business hours: October 1- March 31: 8 a.m. to 8 p.m. 7 days a week April 1- September 30: 8 a.m. to 8 p.m. Monday-Friday; 8 a.m. to 2 p.m. Saturday</p> <p>After hours, an automated voice messaging service is available. If you leave a message, please include your name, phone number and the time you called. A Customer Service Representative will return your call within one business day.</p>
TTY	<p>TTY users call PA Relay: 711 or 1-800-654-5984 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.</p> <p>Our business hours: October 1- March 31: 8 a.m. to 8 p.m. 7 days a week April 1- September 30: 8 a.m. to 8 p.m. Monday-Friday; 8 a.m. to 2 p.m. Saturday</p>
FAX	570-300-2122
WRITE	Geisinger Gold Pharmacy Department 100 North Academy Avenue Danville, PA 17822-2410
WEBSITE	www.GeisingerGold.com

How to contact us when you are making a complaint about your medical care

You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Chapter 2 Important phone numbers and resources

Method	Complaints About Medical Care – Contact Information
CALL	<p>1-800-498-9731 Calls to this number are</p> <p>Our business hours: October 1- March 31: 8 a.m. to 8 p.m. 7 days a week April 1- September 30: 8 a.m. to 8 p.m. Monday-Friday; 8 a.m. to 2 p.m. Saturday</p> <p>After hours, an automated voice messaging service is available. If you leave a message, please include your name, phone number and the time you called. A Customer Service Representative will return your call within one business day.</p>
TTY	<p>TTY users call PA Relay: 711 or 1-800-654-5984 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.</p> <p>Our business hours: October 1- March 31: 8 a.m. to 8 p.m. 7 days a week April 1- September 30: 8 a.m. to 8 p.m. Monday-Friday; 8 a.m. to 2 p.m. Saturday</p>
FAX	1-570-271-7225 Attention: Member Resolution Team
WRITE	Geisinger Gold Member Resolution Team 100 North Academy Avenue Danville, PA 17822-3220
MEDICARE WEBSITE	<p>You can submit a complaint about Geisinger Gold Secure Rx (HMO D-SNP) directly to Medicare. To submit an online complaint to Medicare go to</p> <p>www.medicare.gov/MedicareComplaintForm/home.aspx</p>

Chapter 2 Important phone numbers and resources

Method	Complaints About Part D prescription drugs – Contact Information
CALL	<p>1-800-988-4861 Calls to this number are</p> <p>Our business hours: October 1- March 31: 8 a.m. to 8 p.m. 7 days a week April 1- September 30: 8 a.m. to 8 p.m. Monday-Friday; 8 a.m. to 2 p.m. Saturday</p> <p>After hours, an automated voice messaging service is available. If you leave a message, please include your name, phone number and the time you called. A Customer Service Representative will return your call within one business day.</p>
TTY	<p>TTY users call PA Relay: 711 or 1-800-654-5984 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.</p> <p>Our business hours: October 1- March 31: 8 a.m. to 8 p.m. 7 days a week April 1- September 30: 8 a.m. to 8 p.m. Monday-Friday; 8 a.m. to 2 p.m. Saturday</p>
FAX	1-570-271-7225 Attention: Member Resolution Team
WRITE	Geisinger Gold Member Resolution Team 100 North Academy Avenue Danville, PA 17822-3220
MEDICARE WEBSITE	<p>You can submit a complaint about Geisinger Gold Secure Rx (HMO D-SNP) directly to Medicare. To submit an online complaint to Medicare go to</p> <p>www.medicare.gov/MedicareComplaintForm/home.aspx</p>

Where to send a request asking us to pay the cost for medical care or a drug you have received

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. See Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).

Geisinger Gold is not allowed to reimburse members for Pennsylvania Medical Assistance (Medicaid) covered benefits. If you have questions, please contact Member Services at the phone number listed at the beginning of this section.

Chapter 2 Important phone numbers and resources

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for more information.

Method	Medical Payment Requests – Contact Information
CALL	1-800-498-9731 Calls to this number are free. Our business hours: October 1- March 31: 8 a.m. to 8 p.m. 7 days a week April 1- September 30: 8 a.m. to 8 p.m. Monday-Friday; 8 a.m. to 2 p.m. Saturday
TTY	TTY users call PA Relay: 711 or 1-800-654-5984 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Our business hours: October 1- March 31: 8 a.m. to 8 p.m. 7 days a week April 1- September 30: 8 a.m. to 8 p.m. Monday-Friday; 8 a.m. to 2 p.m. Saturday
FAX	570-271-5871
WRITE	Geisinger Gold P.O. Box 853910 Richardson, TX 75085-3910
WEBSITE	www.GeisingerGold.com

Method	Part D prescription drug Payment Requests – Contact Information
CALL	1-800-988-4861 Calls to this number are free. Our business hours: October 1- March 31: 8 a.m. to 8 p.m. 7 days a week April 1- September 30: 8 a.m. to 8 p.m. Monday-Friday; 8 a.m. to 2 p.m. Saturday

Chapter 2 Important phone numbers and resources

Method	Part D prescription drug Payment Requests – Contact Information
TTY	<p>TTY users call PA Relay: 711 or 1-800-654-5984 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.</p> <p>Our business hours: October 1- March 31: 8 a.m. to 8 p.m. 7 days a week April 1- September 30: 8 a.m. to 8 p.m. Monday-Friday; 8 a.m. to 2 p.m. Saturday</p>
FAX	570-300-2122
WRITE	<p>Geisinger Gold Pharmacy Department 100 North Academy Avenue Danville, PA 17822-2410</p>
WEBSITE	www.GeisingerGold.com

SECTION 2 Medicare (how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called “CMS”). This agency contracts with Medicare Advantage organizations including us.

Method	Medicare – Contact Information
CALL	<p>1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.</p>
TTY	<p>1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.</p>

Chapter 2 Important phone numbers and resources

Method	Medicare – Contact Information
WEBSITE	<p data-bbox="415 317 667 348">www.medicare.gov</p> <p data-bbox="415 363 1404 541">This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state.</p> <p data-bbox="415 556 1349 625">The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:</p> <ul data-bbox="464 640 1404 905" style="list-style-type: none"> <li data-bbox="464 640 1325 709">• Medicare Eligibility Tool: Provides Medicare eligibility status information. <li data-bbox="464 724 1404 905">• Medicare Plan Finder: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an <i>estimate</i> of what your out-of-pocket costs might be in different Medicare plans. <p data-bbox="415 919 1404 989">You can also use the website to tell Medicare about any complaints you have about Geisinger Gold Secure Rx (HMO D-SNP):</p> <ul data-bbox="464 1003 1404 1220" style="list-style-type: none"> <li data-bbox="464 1003 1404 1220">• Tell Medicare about your complaint: You can submit a complaint about Geisinger Gold Secure Rx (HMO D-SNP) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. <p data-bbox="415 1234 1404 1451">If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)</p>

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions 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 Pennsylvania Medicare Education and Decision Insight (PA MEDI).

Chapter 2 Important phone numbers and resources

Pennsylvania Medicare Education and Decision Insight (PA MEDI) is an independent (not connected with any insurance company or health plan) state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Pennsylvania Medicare Education and Decision Insight (PA MEDI) counselors can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. Pennsylvania Medicare Education and Decision Insight (PA MEDI) counselors can also help you with Medicare questions or problems and help you understand your Medicare plan choices and answer questions about switching plans.

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit www.medicare.gov
- Click on Get Help in the “**Talk to Someone**” box in the middle of the homepage
- You now have the following options
 - Option #1: You can have a **live chat with a 1-800-MEDICARE representative**
 - Option #2: You can select your **STATE** from the dropdown menu and click GO. This will take you to a page with phone numbers and resources specific to your state.

Method	Pennsylvania Medicare Education and Decision Insight (PA MEDI) (SHIP) – Contact Information
CALL	1-800-783-7067 Calls to this number are free
WRITE	Pennsylvania Medicare Education and Decision Insight (PA MEDI) Pennsylvania Department of Aging 555 Walnut Street 5th Floor Harrisburg, PA 17101-1919
WEBSITE	www.aging.pa.gov/aging-services/medicare-counseling/Pages/default.aspx

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For Pennsylvania, the Quality Improvement Organization is called Livanta.

Chapter 2 Important phone numbers and resources

Livanta has a group of doctors and other health care professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare. Livanta is an independent organization. It is not connected with our plan.

You should contact Livanta in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Method	Livanta (Pennsylvania's Quality Improvement Organization) – Contact Information
CALL	1-888-396-4646 Calls to this number are free Hours are Monday - Friday: 9:00 a.m. - 5:00 p.m. (local time); Weekends and Holidays: 11:00 a.m. - 3:00 p.m. 24-hour voice mail is available.
TTY	1-888-985-2660 Calls to this number are free This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	1-833-868-4057
WEBSITE	www.BFCCQIOAREA1.com

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

Method	Social Security – Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can use Social Security’s automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday.
WEBSITE	www.ssa.gov

SECTION 6 Pennsylvania Medical Assistance (Medicaid)

Pennsylvania Medical Assistance (Medicaid) is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.

In addition, there are programs offered through Pennsylvania Medical Assistance (Medicaid) that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These “Medicare Savings Programs” help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB)+:** An individual who meets the standards for QMB eligibility, and who also meets the criteria for full Medicaid benefits. Pennsylvania Medical Assistance (Medicaid) pays their Medicare Part A premiums, if any, Medicare Part B premiums, Medicare deductibles and coinsurance, and provides full Pennsylvania Medical Assistance (Medicaid) benefits to the extent consistent with the State Plan.
- **SLMB+:** An individual who meets the standards for SLMB eligibility, and who also meets the criteria for full State Medicaid benefits. These individuals are entitled to payment of the Medicare Part B premium, in addition to full State Medicaid benefits.
- **Full Benefit Dual Eligible (FBDE):** Eligible for Medicaid either categorically or through optional coverage groups.

Pennsylvania Medical Assistance (Medicaid) Benefits

Chapter 2 Important phone numbers and resources

Geisinger Gold Secure Rx (HMO D-SNP) is a Medicare Advantage Special Needs Plan for people who have both Medicare and Pennsylvania Medical Assistance (Medicaid). This Evidence of Coverage tells you about your **Medicare** benefits, and some additional benefits provided by Geisinger Gold.

In addition to the Medicare Benefits described in this Evidence of Coverage document, you also have **Pennsylvania Medical Assistance (Medicaid)** benefits that will cover your cost sharing, plus some services, drugs and other items not covered by your Geisinger Gold Secure Rx (HMO D-SNP) Plan.

Below is a list, provided by the Commonwealth of Pennsylvania, of the Pennsylvania Medical Assistance (Medicaid) benefits offered to **full benefit Dual Eligible Pennsylvania Medical Assistance (Medicaid) recipients**.

Medicare coverage must be used first, and the Pennsylvania Medical Assistance (Medicaid) Program may then cover payment of Pennsylvania Medical Assistance (Medicaid) covered services.

Please Note: Geisinger Gold Secure Rx (HMO D-SNP) does not administer your Pennsylvania Medical Assistance (Medicaid) benefits. Covered Pennsylvania Medical Assistance (Medicaid) services will be administered by your Community HealthChoices (CHC) plan. Please contact your local County Assistance Office or your CHC plan for more information or for assistance with your Pennsylvania Medical Assistance (Medicaid) benefits. You can find phone numbers for the CHC plans in Chapter 2, Section 6 of this document.

Commonwealth of Pennsylvania Full benefit Pennsylvania Medical Assistance (Medicaid) Benefits and Home and Community Based Services (HCBS) Waiver Services:

Pennsylvania Medical Assistance (Medicaid) State Plan Benefits and Home and Community Based Services (HCBS) Waiver Services as Identified by Pennsylvania Medical Assistance (Medicaid) for Benefit Coordination Purposes.

Pennsylvania Medicaid State Plan Benefits and

Home and Community Based Services

Adult Benefit Package*	
Services	Adult Benefit Package
Category 1: Ambulatory Services	
Primary Care Provider	No limits
Physician Services and Medical and Surgical Services provided by a Dentist	No limits
Certified Registered Nurse Practitioner	No limits
Federally Qualified Health Center/Rural Health Clinic	No limits except for Dental Care Services as described below

Chapter 2 Important phone numbers and resources

Adult Benefit Package*	
Services	Adult Benefit Package
Independent Clinic	No limits
Outpatient Hospital Clinic	No limits
Podiatrist Services	No limits
Chiropractor Services	No limits
Optometrist Services	2 visits (exams) per calendar year
Hospice Care	The only key limitation is related to respite care, which may not exceed a total of 5 consecutive days in a 60-day certification period.
Radiology (For example: X-Rays, MRIs, and CTs)	No limits
Dental Care Services	<p>Diagnostic, preventive, restorative, surgical dental procedures, prosthodontics and sedation.</p> <p>Key Limitations:</p> <p>Dentures – 1 upper arch (complete or partial) and 1 lower arch (complete or partial) per lifetime</p> <p>Denture relines – either full or partial, limited to 1 arch every 2 calendar years.</p> <p>Exams 1 per 180 days</p> <p>Prophylaxis 1 per 180 days</p> <p>Panoramic maxilla or mandible single film is limited to 1 per 5 calendar years.</p> <p>Crowns, Periodontics and Endodontics only via approved benefit limit exception.</p>
Outpatient Hospital Short Procedure Unit (SPU)	No limits
Outpatient Ambulatory Surgical Center (ASC)	No limits
Non-Emergency Medical Transport	Only to and from Medicaid covered services.
Family Planning Clinic, Services and Supplies	No limits
Renal Dialysis	Initial training for home dialysis is limited to 24 sessions per patient per calendar year. Backup visits to the facility limited to no more than 75 per calendar year.
Category 2: Emergency Services	
Emergency Room	No limits
Ambulance	No limits
Category 3: Hospitalization	
Inpatient Acute Hospital	No limits
Inpatient Rehab Hospital	No limits

Chapter 2 Important phone numbers and resources

Adult Benefit Package*	
Services	Adult Benefit Package
Inpatient Psychiatric Hospital	No limits
Inpatient Drug & Alcohol	No limits
Category 4: Maternity and Newborn	
Maternity - Physician, Certified Nurse Midwives, Birth Centers	No limits
Category 5: Mental Health and Substance Abuse (Behavioral Health)	
Outpatient Psychiatric Clinic	No limits
Mobile Mental Health Treatment	No limits
Outpatient Drug and Alcohol Treatment	No limits
Methadone Maintenance	No limits
Clozapine	No limits
Psychiatric Partial Hospital	No limits
Peer Support	No limits
Crisis	No limits
Targeted Case Management – other than Behavioral Health	Limited to individuals identified in the target group (No limits).
Targeted Case Management – Behavioral Health Only	Limited to individuals with Serious Mental Illness (SMI) only (No limits).
Category 6: Prescription Drugs	
Prescription Drugs	No limits
Nutritional Supplements	No limits
Category 7: Rehabilitation and Habilitation Services and Devices	
Skilled Nursing Facility	365 days per calendar year
Home Health Care includes nursing, aide and therapy services.	Unlimited for first 28 days; limited to 15 days every month thereafter.
Intermediate Care Facilities/individuals with Intellectual Disabilities (ICF/IID) and Intermediate Care Facilities/for people with Other Related Conditions (ICF/ORC)	Requires an institutional level of care (No limits).
Durable Medical Equipment	No limits
Prosthetics and Orthotics	<p>Orthopedic Shoes and Hearing Aids are not covered.</p> <p>Coverage of molded shoes is limited to molded shoes for severe foot and ankle conditions and deformities of such a degree that the beneficiary is unable to wear ordinary shoes without corrections and modifications</p> <p>Coverage of modifications to orthopedic shoes and molded shoes is limited to only modifications necessary for the application of a brace or splint</p>

Chapter 2 Important phone numbers and resources

Adult Benefit Package*	
Services	Adult Benefit Package
	Coverage for low vision aids and eye protheses is limited to 1 per 2 calendar years. Coverage for an eye ocular is limited to 1 per calendar year.
Eyeglass Lenses	Limited to individuals diagnosed with aphakia 4 lenses per calendar year.
Eyeglass Frames	Limited to individuals diagnosed with aphakia 2 frames per calendar year. Deluxe frames not included.
Contact Lenses	Limited to individuals diagnosed with aphakia 4 lenses per calendar year.
Medical Supplies	No limits
Therapy (physical, occupational, speech) - Rehabilitative	Only when provided by a hospital, outpatient clinic, or home health provider.
Therapy (physical, occupational, speech) - Habilitative	Only when provided by a hospital, outpatient clinic, or home health provider.
Category 8: Laboratory Services	
Laboratory	No limits
Category 9: Preventative / Wellness Services and Chronic Care	
Tobacco Cessation**	70, 15-minute units per calendar year

All units of service, age, gender, diagnosis, and other procedure code related limits still apply as indicated on the Medical Assistance Fee Schedule.

***Children's benefit plan will include all medically necessary services without limitation.**

****Tobacco cessation is one of the preventative services as recommended by the US Preventative Services Task Force. For a full listing of preventative services beyond tobacco cessation, please contact your Managed Care Organization (MCO).**

Home and Community-Based Services (HCBS)	
Services	Limits
Adult Daily Living Services	Under Community Integration:
Assistive Technology	Each distinct goal may not be more than twenty-six (26) weeks.
Behavior Therapy	No more than 32 units per week for one goal will be approved. If the participant has multiple goals, no more than 48 units per week will be approved.
Benefits Counseling	
Career Assessment	
	However, the Office of Long-Term Living

Chapter 2 Important phone numbers and resources

Home and Community-Based Services (HCBS)	
Services	Limits
Cognitive Rehabilitation Therapy	retains the discretion to authorize more than 48 units (12 hours) of Community Integration in one week for up to 21 hours per week and for periods longer than 26 weeks.
Community Integration	
Community Transition Services	
Counseling	Community Transition Services are limited to an aggregate of \$4,000 per participant, per lifetime, as preauthorized by the State Medicaid Agency program office.
Employment Skills Development	
Home Adaptations	Total combined hours for Employment Skills Development, or Job Coaching services are limited to 50 hours in a calendar week. A participant whose needs exceed 50 hours a week must obtain prior approval.
Home Delivered Meals	
Home Health Aide	
Home Health – Nursing	
Home Health - Occupational Therapy	Under Specialized Medical Equipment and Supplies non-covered items include:
Home Health - Physical Therapy	
Home Health - Speech and Language Therapy	
Job Coaching	All prescription and over the counter medications, compounds and solutions (except wipes and barrier cream)
Job Finding	Items covered under third party payer Liability
Non-Medical Transportation	
Nutritional Counseling	Items that do not provide direct medical or remedial benefit to the participant and/or are not directly related to a participant's disability
Participant-Directed Community Supports	
Participant-Directed Goods and Services	Food, food supplements, food substitutes (including formulas), and thickening agents
Personal Assistance Services	
Personal Emergency Response System (PERS)	Eyeglasses, frames, and lenses
Pest Eradication	Dentures
	Any item labeled as experimental that

Chapter 2 Important phone numbers and resources

Home and Community-Based Services (HCBS)	
Services	Limits
Residential Habilitation	has been denied by Medicare and/or Medicaid Recreational or exercise equipment and adaptive devices for such
Respite	
Service Coordination	
Specialized Medical Equipment and Supplies	
Structured Day Habilitation	
TeleCare	
Vehicle Modifications	

For all Home and Community-Based Services (HCBS) that are also offered under the State Plan, the State Plan benefit must be exhausted before HCBS services can be accessed. Additionally, Medicare and other third-party resources such as private insurance limitations must also have been exhausted. Lastly, some HCBS services may not be accessed at the same time.

If you have questions about the assistance you get from Pennsylvania Medical Assistance (Medicaid), contact the Pennsylvania Department of Human Services (DHS), Pennsylvania Medical Assistance (Medicaid) program or your Community HealthChoices plan by calling the phone numbers listed below, or by contacting your local County Assistance Office.

Method	Pennsylvania Department of Human Services, Medical Assistance (Medicaid program) – Contact Information
CALL	1-800-692-7462 Department of Human Services Helpline Hours: Monday - Friday 8:30 a.m. - 5:00 p.m.
TTY	1-800-451-5886 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
VISIT	You may visit your local county assistance office. A list of county assistance offices is available online at the state website listed below.
WEBSITE	www.dhs.pa.gov/Services/Assistance/Pages/Medical-Assistance.aspx

Community HealthChoices (CHC) Plan at:

CHC Plan	Website	Call	TTY
AmeriHealth Caritas Pennsylvania	http://www.amerihealthcaritaschc.com	1-855-235-5115	1-855-235-5112
Keystone First Community HealthChoices	http://www.keystonefirstchc.com	1-855-332-0729	1-855-235-4976
PA Health & Wellness	https://www.pahealthwellness.com	1-844-626-6813	1-844-349-8916
UPMC Community HealthChoices	https://www.upmchealthplan.com/chc	1-844-833-0523	1-866-407-8762

Your local Pennsylvania County Assistance Office helps people enrolled in Pennsylvania Medical Assistance (Medicaid) with Pennsylvania Medical Assistance (Medicaid) service or billing problems.

Pennsylvania County Assistance Offices:

County	Assistance Office Address	Telephone/Fax Numbers
Adams	Adams County Assistance Office	Toll Free: 1-800-638-6816
	225 South Franklin Street	Phone: 717-334-6241
	P.O. Box 4446	Fax: 717-334-4104
	Gettysburg, PA 17325-4446	
	Office Hours: 8:30 am – 5:00 pm	
Armstrong	Armstrong County Assistance Office	Toll Free: 1-800-424-5235
	1280 North Water Street	Phone: 724-543-1651
	Kittanning, PA 16201-0898	Fax: 724-548-0274
	Office Hours: 7:30 am - 5:00 pm	
Beaver	Beaver County Assistance Office	Toll Free: 1-800-653-3129
	171 Virginia Avenue	Phone: 724-773-7300
	P.O. Box 349	Fax: 724-773-7859
	Rochester, PA 15074-0349	
	Office Hours: 7:00 am - 5:00 pm	

County	Assistance Office Address	Telephone/Fax Numbers
Bedford	Bedford County Assistance Office	Toll Free: 1-800-542-8584
	150 North Street	Phone: 814-623-6127
	Bedford, PA 15522-1040	Fax: 814-623-7310
	Office Hours: 8:00 am - 5:00 pm	
Berks	Berks County Assistance Office	Toll Free: 1-866-215-3912
	Reading State Office Building	Phone: 610-736-4211
	625 Cherry Street	Fax: 610-736-4004
	Reading, PA 19602-1188	
Office Hours: 8:00 am – 5:00 pm		
Blair	Blair County Assistance Office	Toll Free: 1-866-812-3341
	1100 Green Avenue	Fax: 814-941-6813
	Altoona, PA 16601-3440	
Office Hours: 7:30 am – 5:00 pm		
Bradford	Bradford County Assistance Office	Toll Free: 1-800-542-3938
	1 Elizabeth Street, Suite 4	Phone: 570-265-9186
	PO Box 398	Fax: 570-265-3061
	Towanda, PA 18848-0398	
Office Hours: 8:00 am – 5:00 pm		
Bucks	Bucks County Assistance Office	Toll Free: 1-800-362-1291
	1214 Veterans Highway	Phone: 215-781-3300
	Bristol, PA 19007-2593	Fax: 215-781-3438
Office Hours: 8:00 am – 5:00 pm		
Butler	Butler County Assistance Office	Toll Free: 1-866-256-0093
	108 Woody Drive	Phone: 724-284-8844
	Butler, PA 16001-5692	Fax: 724-284-8833
Office Hours 7:30 am - 5:00 pm		
Cambria	Cambria County Assistance Office	Toll Free: 1-877-315-0389
	625 Main Street	Phone: 814-533-2491
	Johnstown, PA 15901-2121	Fax: 814-533-2214
Office Hours: 7:00 am – 5:00 pm		

County	Assistance Office Address	Telephone/Fax Numbers
Cameron	Cameron County Assistance Office	Toll Free: 1-877-855-1824
	411 Chestnut Street	Phone: 814-486-3757
	P.O. Box 71	Fax: 814-486-1379
	Emporium, PA 15834-0071	
	Office Hours: 8:30 am – 5:00 pm	
Carbon	Carbon County Assistance Office	Toll Free: 1-800-314-0963
	101 Lehigh Drive	Phone: 610-577-9020
	Lehighton, PA 18235	Fax: 610-577-9043
	Office Hours: 7:30 am – 5:00 pm	
Centre	Centre County Assistance Office	Toll Free: 1-800-355-6024
	2580 Park Center Boulevard	Phone: 814-863-6571
	State College, PA 16801-3005	Fax: 814-689-1356
	Office Hours: 8:00 am – 5:00 pm	
Chester	Chester County Assistance Office	Toll Free: 1-888-814-4698
	100 James Buchanan Drive	Phone: 610-466-1000
	Thorndale, PA 19372-1132	Fax: 610-466-1130
	Office Hours: 8:00 am – 5:00 pm	
Clarion	Clarion County Assistance Office	Toll Free: 1-800-253-3488
	71 Lincoln Drive	Phone: 814-226-1700
	Clarion, PA 16214-3861	Fax: 814-226-1794
	Office Hours: 8 am - 5:00 pm	
Clearfield	Clearfield County Assistance Office	Toll Free: 1-800-521-9218
	1025 Leonard Street	Phone: 814-765-7591
	Clearfield, PA 16830	Fax: 814-765-0802
	Office Hours: 7:30 am – 5:00 pm	
Clinton	Clinton County Assistance Office	Toll Free: 1-800-820-4159
	300 Bellefonte Avenue, Suite 101	Phone: 570-748-2971
	Lock Haven, PA 17745-1929	Fax: 570-893-2973
	Office Hours: 7:30 am – 5:00 pm	

County	Assistance Office Address	Telephone/Fax Numbers
Columbia	Columbia County Assistance Office	Toll Free: 1-877-211-1322
	27 East Seventh Street	Phone: 570-387-4200
	P.O. Box 628	Fax: 570-387-4708
	Bloomsburg, PA 17815-0628	
	Office Hours: 8:00 am – 5:00 pm	
Crawford	Crawford County Assistance Office	Toll Free: 1-800-527-7861
	1084 Water Street	Phone: 814-333-3400
	P.O. Box 1187	Fax: 814-333-3527
	Meadville, PA 16335-7187	
	Office Hours: 7:30 am - 5:00 pm	
Cumberland	Cumberland County Assistance Office	Toll Free: 1-800-269-0173
	33 Westminster Drive	Phone: 717-240-2700
	Carlisle, PA 17013-0599	Fax: 717-240-2781
	Office Hours: 7:45 am – 5:00 pm	
Dauphin	Dauphin County Assistance Office	Toll Free: 1-800-788-5616
	2432 N. 7th Street	Phone: 717-787-2324
	P.O. Box 5959	Fax: 717-772-4703
	Harrisburg, PA 17110-0959	
	Office Hours: 8:00 am – 5:00 pm	
Delaware	Delaware County Assistance Office	Phone: 610-447-5500
	Headquarters	Fax: 610-447-5399
	701 Crosby Street, Suite A	
	Chester, PA 19013-6099	
	Office Hours: 8:00 am - 5:00 pm	
	Crosby District	Phone: 610-447-5500
	701 Crosby Street, Suite A	Fax: 610-447-5399
	Chester, PA 19013-6099	
	Office Hours: 8:00 am - 5:00 pm	
	Darby District	Phone: 610-461-3800
	845 Main Street	Fax: 610-461-3900
Darby, PA 19023		

County	Assistance Office Address	Telephone/Fax Numbers
	Office Hours: 8:00 am - 5:00 pm	
Elk	Elk County Assistance Office	Toll Free: 1-800-847-0257
	145 Race Street	Phone: 814-776-1101
	P.O. Box F	Fax: 814-772-7007
	Ridgway, PA 15853-0327	
	Office Hours 7:30 am - 5:00 pm	
Forest	Forest County Assistance Office	Toll Free: 1-800-876-0645
	106 Sherman Street	Phone: 814-755-3552
	Tionesta, PA 16353	Fax: 814-755-3420
	Office Hours: 7:30am - 5:00 pm	
Franklin	Franklin County Assistance Office	Toll Free: 1-877-289-9177
	620 Norland Avenue	Phone: 717-264-6121
	Chambersburg, PA 17201-4205	Fax: 717-264-4801
	Office Hours: 8:00 am – 5:00 pm	
Fulton	Fulton County Assistance Office	Toll Free: 1-800-222-8563
	539 Fulton Drive	Phone: 717-485-3151
	McConnellsburg, PA 17233	Fax: 717-485-3713
	Office Hours: 8:00 am – 5:00 pm	
Greene	Greene County Assistance Office	Toll Free: 1-888-410-5658
	108 Greene Plaza, Suite 1	Phone: 724-627-8171
	Waynesburg, PA 15370-0950	Fax: 724-627-8096
	Office Hours: 8:00 am – 5:00 pm	
Huntingdon	Huntingdon County Assistance Office	Toll Free: 1-800-237-7674
	7591 Lake Raystown Shopping Center	Phone: 814-643-1170
	Huntingdon, PA 16652-0398	Fax: 814-643-5441
	Office Hours: 7:30 am – 5:00 pm	
Jefferson	Jefferson County Assistance Office	Toll Free: 1-800-242-8214
	100 Prushnok Drive	Phone: 814-938-2990
	P.O. Box 720	Fax: 814-938-3842
	Punxsutawney, PA 15767-0720	
	Office Hours: 8:30 am – 5:00 pm	

County	Assistance Office Address	Telephone/Fax Numbers
Juniata	Juniata County Assistance Office	Toll Free: 1-800-586-4282
	100 Meadow Lane	Phone: 717-436-2158
	P.O. Box 65	Fax: 717-436-5402
	Mifflintown, PA 17059-9983	
	Office Hours: 8:30 am – 5:00 pm	
Lackawanna	Lackawanna County Assistance Office	Toll Free: 1-877-431-1887
	200 Scranton State Office Building	Phone: 570-963-4525
	100 Lackawanna Avenue	Fax: 570-963-4843
	Scranton, PA 18503-1972	
	Office Hours: 7:30 am – 5:00 pm	
Lancaster	Lancaster County Assistance Office	Phone: 717-299-7411
	832 Manor Street	Fax: 717-299-7565
	P.O. Box 4967	
	Lancaster, PA 17604-4967	
	Office Hours: 8:00 am – 5:00 pm	
Lebanon	Lebanon County Assistance Office	Toll Free: 1-800-229-3926
	625 South Eighth Street	Phone: 717-270-3600
	Lebanon, PA 17042-6762	Fax: 717-228-2589
	Office Hours: 8:00 am – 5:00 pm	
Lehigh	Lehigh County Assistance Office	Toll Free: 1-877-223-5956
	555 Union Blvd., Suite 3	Phone: 610-821-6509
	Allentown, PA 18109-3389	Fax: 610-821-6705
	Office Hours: 7:30 am – 5:00 pm	
Luzerne	Luzerne County Assistance Office	Toll Free: 1-866-220-9320
	Wilkes-Barre District	Phone: 570-826-2100
	205 South Washington Street	Fax: 570-826-2178
	Wilkes-Barre, PA 18711-3298	
	Office Hours: 7:30 am – 5:00 pm	
	Hazleton District	Phone: 570-459-3800
	Center Plaza Building	Fax: 570-459-3931
	10 West Chestnut Street	
	Hazleton, PA 18201-6409	

County	Assistance Office Address	Telephone/Fax Numbers
	Office Hours: 7:30 am – 5:00 pm	
Lycoming	Lycoming County Assistance Office	Toll Free: 1-877-867-4014
	400 Little League Boulevard	Phone: 570-327-3300
	P.O. Box 127	Fax: 570-321-6501
	Williamsport, PA 17703-0127	
	Office Hours: 7:30 am – 5:00 pm	
McKean	McKean County Assistance Office	Toll Free: 1-800-822-1108
	68 Chestnut Street, Suite B	Phone: 814-362-4671
	Bradford, PA 16701-0016	Fax: 814-362-4959
	Office Hours: 7:30 am – 5:00 pm	
Mifflin	Mifflin County Assistance Office	Toll Free: 1-800-382-5253
	1125 Riverside Drive	Phone: 717-248-6746
	Lewistown, PA 17044-1942	Fax: 717-242-6099
	Office Hours: 7:30 am – 5:00 pm	
Monroe	Monroe County Assistance Office	Toll Free: 1-877-905-1495
	1972 W. Main Street, Suite 101	Phone: 570-424-3030
	Stroudsburg, PA 18360-0232	Fax: 570-424-3915
	Office Hours: 7:30 am – 5:00 pm	
Montour	Montour County Assistance Office	Toll Free: 1-866-596-5944
	497 Church Street	Phone: 570-275-7430
	Danville, PA 17821-2217	Fax: 570-275-7433
	Office Hours: 8:00 am – 5:00 pm	
Northampton	Northampton County Assistance Office	Toll Free: 1-800-349-5122
	201 Larry Holmes Drive	Phone: 610-250-1700
	P.O. Box 10	Fax: 610-250-1839
	Easton, PA 18044-0010	
	Office Hours: 7:30 am – 5:00 pm	
Northumberland	Northumberland County Assistance Office	Toll Free: 833-299-4361
	320 Chestnut Street	Phone: 570-988-5900
	Sunbury, PA 17801	Fax: 570-988-5918

County	Assistance Office Address	Telephone/Fax Numbers
	Office Hours: 8:00 am – 5:00 pm	
Perry	Perry County Assistance Office	Toll Free: 1-800-991-1929
	100 Centre Drive	Phone: 717-582-2127
	P.O. Box 280	Fax: 717-582-4187
	New Bloomfield, PA 17068-0280	
	Office Hours: 8:30 am – 5:00 pm	
Philadelphia	Philadelphia County Assistance Office	Phone: 215-560-7226
	Headquarters	Fax: 215-560-3214
	801 Market Street	
	Philadelphia, PA 19107	
	Office Hours: 8:00 am - 5:00 pm	
	Boulevard District	Phone: 215-560-6500
	4109 Frankford Avenue	Fax: 215-560-2087
	Philadelphia, PA 19124-4508	
	Office Hours: 8:00 am - 5:00 pm	
	Cheltenham District	Phone: 215-560-5200
	301 East Cheltenham Avenue, 1st Floor	Fax: 215-560-5251
	Philadelphia, PA 19144-5751	
	Office Hours: 8 am - 5:00 pm	
	Delancey District	Phone: 215-560-3700
	5740 Market Street 2nd Floor	Fax: 215-560-2907
	Philadelphia, PA 19139-3204	
Office Hours: 8:00 am - 5:00 pm		
Elmwood District	Phone: 215-560-3800	
5740 Market Street 1st Floor	Fax: 215-560-2065	
Philadelphia, PA 19139-3204		
Office Hours: 8:00 am - 5:00 pm		
Glendale District	Phone: 215-560-4600	
5201 Old York Road	Fax: 215-456-5103	
Philadelphia, PA 19141-9943		
Office Hours: 8:00 am - 5:00 pm		

Chapter 2 Important phone numbers and resources

County	Assistance Office Address	Telephone/Fax Numbers
	Liberty District	Phone: 215-560-4000
	219 East Lehigh Avenue	Fax: 215-560-4065
	Philadelphia, PA 19125-1099	
	Office Hours: 8:00 am - 5:00 pm	
	Long Term and Independent	Phone: 215-560-5500
	Services District	Fax: 215-560-1495
	5070 Parkside Avenue	
	Philadelphia, PA 19131	
	Office Hours: 8:00 am - 5:00 pm	
	Ridge/Tioga District	Phone: 215-560-4900
	1350 West Sedgley Avenue	Fax: 215-560-4938
	Philadelphia, PA 19132-2498	
	Office Hours: 8:00 am - 5:00 pm	
	Somerset District	Phone: 215-560-5400
	2701 N. Broad Street, 2nd Flr.	Fax: 215-560-5403
	Philadelphia, PA 19132-2743	
	Office Hours: 8:00 am - 5:00 pm	
	South District	Phone: 215-560-4400
	1163 S. Broad Street	Fax: 215-218-4650
	Philadelphia, PA 19147	
Office Hours: 8:00 am - 5:00 pm		
Unity District	Phone: 215-560-6400	
4111 Frankford Avenue	Fax: 215-560-2067	
Philadelphia, PA 19124		
Office Hours: 8:00 am - 5:00 pm		
West District	Phone: 215-560-6100	
5070 Parkside Avenue	Fax: 215-560-2053	
Philadelphia, PA 19131-4747		
Office Hours: 8:00 am - 5:00 pm		
Pike County Assistance Office	Toll Free: 1-866-267-9181	
Milford Professional Park	Phone: 570-296-6114	

County	Assistance Office Address	Telephone/Fax Numbers
	Suite 101	Fax: 570-296-4183
	10 Buist Road	
	Milford, PA 18337	
	Office Hours: 8:30 am – 5:00 pm	
Potter	Potter County Assistance Office	Toll Free: 1-800-446-9896
	269 Route 6 West, Room 1	Phone: 814-274-4900
	Coudersport, PA 16915-8465	Fax: 814-274-3635
	Office Hours: 8:30 am – 5:00 pm	
Schuylkill	Schuylkill County Assistance Office	Toll Free: 1-877-306-5439
	2640 Woodglen Road	Phone: 570-621-3000
	P.O. Box 1100	Fax: 570-624-3334
	Pottsville, PA 17901-1100	
	Office Hours: 8:30 am – 5:00 pm	
Snyder	Snyder County Assistance Office	Toll Free: 1-866-713-8584
	83 Maple Lane	Phone: 570-374-8126
	Selinsgrove, PA 17870-1302	Fax: 570-374-6347
	Office Hours: 8:30 am – 5:00 pm	
Somerset	Somerset County Assistance Office	Toll Free: 1-800-248-1607
	164 Staybrook Street	Phone: 814-443-3681
	Somerset, PA 15501	Fax: 814-445-4352
	Office Hours: 7:45 am – 5:00 pm	
Sullivan	Sullivan County Assistance Office	Toll Free: 1-877-265-1681
	918 Main Street, Suite 2	Phone: 570-946-7174
	P.O. Box 355	Fax: 570-946-7189
	Laporte, PA 18626-0355	
	Office Hours: 8:00 am – 5:00 pm	
Susquehanna	Susquehanna County Assistance Office	Toll Free: 1-888-753-6328
	111 Spruce Street	Phone: 570-278-3891
	P.O. Box 128	Fax: 570-278-9508
	Montrose, PA 18801-0128	
	Office Hours: 8:00 am – 5:00 pm	

County	Assistance Office Address	Telephone/Fax Numbers
Tioga	Tioga County Assistance Office	Toll Free: 1-800-525-6842
	11809 Route 6	Phone: 570-724-4051
	Wellsboro, PA 16901-6764	Fax: 570-724-5612
	Office Hours: 8:00 am – 5:00 pm	
Union	Union County Assistance Office	Toll Free: 1-877-628-2003
	Suite 300	Phone: 570-524-2201
	1610 Industrial Boulevard	Fax: 570-524-2361
	Lewisburg, PA 17837-1292	
	Office Hours: 8:30 am – 5:00 pm	
Venango	Venango County Assistance Office	Toll Free: 1-877-409-2421
	530 13th Street	Phone: 814-437-4341/4342
	Franklin, PA 16323-0391	Fax: 814-437-4441
	Office Hours: 7:30 am - 5:00 pm	
Warren	Warren County Assistance Office	Toll Free: 1-800-403-4043
	210 North Drive Suite, A	Phone: 814-723-6330
	North Warren, PA 16365	Fax: 814-726-1565
	Office Hours: 8:00 am – 5:00 pm	
Washington	Washington County Assistance Office	Toll-Free: 1-800-835-9720
	167 North Main Street	Phone: 724-223-4300
	Washington, PA 15301-4354	Fax: 724-223-4675
	Office Hours: 7:30 am - 5:00 pm	
	Valley District	Toll-Free: 1-800-392-6932
	595 Galiffa Drive	Phone: 724-379-1500
	P.O. Box 592	Fax: 724-379-1572
	Donora, PA 15033-0592	
Office Hours: 7:30 am - 5:00 pm		
Wayne	Wayne County Assistance Office	Toll Free: 1-877-879-5267
	15 Innovation Drive	Phone: 570-253-7100
	Lake Ariel, PA 18436-8800	Fax: 717-525-5151
	Office Hours: 8:30 am – 5:00 pm	
Westmoreland	Westmoreland County Assistance Office	Toll Free: 1-800-905-5413

Chapter 2 Important phone numbers and resources

County	Assistance Office Address	Telephone/Fax Numbers
	Main Office	Phone: 724-832-5200
	587 Sells Lane	Fax: 724-832-5202
	Greensburg, PA 15601-4493	
	Office Hours 7:00 am - 5:00 pm	
Wyoming	Wyoming County Assistance Office	Toll Free: 1-877-699-3312
	608 Hunter Highway, Suite 6	Phone: 570-836-5171
	P.O. Box 490	Fax: 570-996-4141
	Tunkhannock, PA 18657-0490	
	Office Hours: 8:00 am – 5:00 pm	
York	York County Assistance Office	Toll Free: 800-991-0929
	130 N. Duke Street	Phone: 717-771-1100
	P.O. Box 15041	Fax: 717-771-1261
	York, PA 17405-7041	
	Office Hours: 8:00 am – 5:00 pm	

The Pennsylvania Office of the State Long-Term Care Ombudsman helps people enrolled in Pennsylvania Medical Assistance (Medicaid) with service or billing problems. They can help you file a grievance or appeal with our plan. They also help people get information about nursing homes and resolve problems between nursing homes and residents or their families.

Method	Office of the State Long-Term Care Ombudsman Pennsylvania Department of Aging – Contact Information
CALL	717-783-8975 or contact your local Area Agency on Aging Monday – Friday 8:30 a.m. – 5:00 p.m.
WRITE	Office of the State Long-Term Care Ombudsman Pennsylvania Department of Aging 555 Walnut Street, 5 th Floor Harrisburg, PA 17101-1919
WEBSITE	www.aging.pa.gov/aging-services/Pages/Ombudsman.aspx A list of county ombudsman offices is also available on this website. More information about the Ombudsman Program is available at this website: www.aging.pa.gov/organization/advocacy-and-protection/Pages/Ombudsman.aspx

SECTION 7 Information about programs to help people pay for their prescription drugs

The Medicare.gov website (<https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/6-ways-to-get-help-with-prescription-costs>) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

Medicare’s “Extra Help” Program

Because you are eligible for Pennsylvania Medical Assistance (Medicaid), you qualify for and are getting “Extra Help” from Medicare to pay for your prescription drug plan costs. You do not need to do anything further to get this “Extra Help.”

If you have questions about “Extra Help,” call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048 (applications), 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 8 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778; or
- Your State Medicaid Office (applications) (See Section 6 of this chapter for contact information).

If you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has a process for you to either request assistance in obtaining evidence of your proper copayment level or if you already have the evidence, to provide this evidence to us.

- Geisinger Gold Pharmacy Member Services will assist you with this process. Please call us at 1-800-988-4861 within 15 days of paying the cost sharing amount that you believe may be incorrect. You may be asked to provide us with documentation about your eligibility for “Extra Help” and the pharmacy receipt for the amount in question. Geisinger Gold Pharmacy Member Services will work with you, Medicare, and your pharmacy to assess if you have paid incorrect cost sharing.
- When we receive the evidence showing your cost-sharing level, we will update our system so that you can pay the correct cost-sharing when you get your next prescription at the pharmacy. If you overpay your cost-sharing, we will reimburse you. Either we will forward a check to you in the amount of your overpayment, or we will offset future cost-sharing. If the pharmacy hasn’t collected a cost-sharing from you and is carrying your cost-sharing as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Pharmacy Member Services if you have questions.

Chapter 2 Important phone numbers and resources**What if you have coverage from a State Pharmaceutical Assistance Program (SPAP)?**

Many states and the U.S. Virgin Islands offer help paying for prescriptions, drug plan premiums and/or other drug costs. If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than “Extra Help”), you still get the 70% discount on covered brand name drugs. Also, the plan pays 5% of the costs of brand drugs in the coverage gap. The 70% discount and the 5% paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

What if you have coverage from an AIDS Drug Assistance Program (ADAP)?**What is the 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 on the ADAP formulary 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 change plans, please notify your local ADAP enrollment worker so you can continue to receive 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.

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, medical condition, or disabilities. Each state has different rules to provide drug coverage to its members.

In Pennsylvania, the State Pharmaceutical Assistance Program is PACE and PACENET.

Method	PACE and PACENET (Pennsylvania’s State Pharmaceutical Assistance Program) – Contact Information
CALL	1-800-225-7223
TTY	1-800-222-9004 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	PACE/PACENET Program P.O. Box 8806 Harrisburg, PA 17105-8806
WEBSITE	pacecares.magellanhealth.com

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation’s railroad workers and their families. If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. If you press “0,” you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press “1”, you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are <i>not</i> free.
WEBSITE	rrb.gov/

SECTION 9 You can get assistance from Pennsylvania Area Agencies on Aging, Geisinger Health Plan Health and Wellness Programs, the Pennsylvania Department of Aging, and the Pennsylvania Department of Human Services

Geisinger Health Plan Health and Wellness Education Programs

Health Management programs focus on health conditions including education and management (in conjunction with your PCP) of Asthma, Chronic Obstructive Pulmonary Disease (COPD), Heart Failure (HF), Coronary Artery Disease (previous heart attack, angina, coronary bypass), Diabetes, High Blood Pressure (Hypertension), Osteoporosis and Tobacco Cessation. Health Management nurses work with your health care Provider to promote optimal monitoring of medication and lifestyle management.

Chapter 2 Important phone numbers and resources

If you have questions regarding these programs, please contact the Geisinger Health Plan Health Management Department toll free at 1-800-883-6355, Monday through Friday, 8:00 a.m. to 4:30 p.m.

Commonwealth of Pennsylvania, Department of Aging

This Pennsylvania Department of Aging webpage has links to local Area Agencies on Aging, and many other local resources that provide assistance to older Pennsylvanians.

www.aging.pa.gov. You can also reach the Pennsylvania Department of Aging at (717) 783-1550 or via Email at aging@pa.gov

Area Agencies on Aging

Pennsylvania's Area Agencies on Aging are non-profit organizations funded by Federal, State, and County governments to assist older adults by promoting the ability to live with independence and dignity.

Area Agencies on Aging (AAA) can assist you with a variety of services, information and referrals. Specific services available at each agency vary throughout the state, but each agency offers a wide array of programs to help older Pennsylvanians and their families get the help and information they need.

Your local Area Agency on Aging can assist you with services such as transportation, care management, counseling, senior centers, meal services, protective services, personal care, home support, information on housing options and long-term care, adult day care, legal assistance, ombudsman and other services that may be available in your community.

Contact the Area Agency on Aging (AAA) that serves your county for information on the services available in your area at www.aging.pa.gov.

Commonwealth of Pennsylvania Department of Human Services

Links are available on this Pennsylvania Department of Human Services website at www.dhs.pa.gov for various Pennsylvania adult assistance programs, such as Services for Persons with Disabilities, Heating Assistance (LIHEAP), Cash Assistance, Hearings and Appeals process, and other services and programs administered by the Pennsylvania Department of Human Services.

You can also contact the Pennsylvania Department of Human Services by phone at 1-800-692-7462.

CHAPTER 3:

*Using the plan for your medical
services*

SECTION 1 Things to know about getting your medical care as a member of our plan

This chapter explains what you need to know about using the plan to get your medical care and other services covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, equipment, prescription drugs, and other medical care that are covered by the plan.

For the details on what medical care and other services are covered by our plan, use the benefits chart in the next chapter, Chapter 4 (*Medical Benefits Chart, what is covered*).

Section 1.1	What are “network providers” and “covered services”?
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- **“Providers”** are doctors and other health care professionals licensed by the state to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.
- **“Network providers”** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay nothing for covered services.
- **“Covered services”** include all the medical care, health care services, supplies, equipment, and Prescription Drugs that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

Section 1.2	Basic rules for getting your medical care covered by the plan
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As a Medicare health plan, Geisinger Gold Secure Rx (HMO D-SNP) must cover all services covered by Original Medicare and may offer other services in addition to those covered under Original Medicare.

Geisinger Gold Secure Rx (HMO D-SNP) will generally cover your medical care as long as:

- **The care you receive is included in the plan’s Medical Benefits Chart** (this chart is in Chapter 4 of this document).
- **The care you receive is considered medically necessary.** “Medically necessary” means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).

Chapter 3 Using the plan for your medical services

- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan’s network) will not be covered. This means that you will have to pay the provider in full for the services furnished. *Here are three exceptions:*
 - The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
 - If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. Authorization must be obtained from our plan prior to seeking care. In this situation, we will cover these services as if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.3 in this chapter.
 - The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan’s service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay the plan for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan’s service area and obtain the dialysis from a provider that is outside the plan’s network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from a provider outside the plan’s network the cost sharing for the dialysis may be higher.

SECTION 2 Use providers in the plan’s network to get your medical care and other services

Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your care
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What is a “PCP” and what does the PCP do for you?

When you become a member of our plan, you must choose a network provider to be your Primary Care Provider (PCP). Your PCP is a physician who meets state requirements and is trained to give you routine medical care. You will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a member of our plan. Your PCP will provide most of your care and will help you arrange or coordinate the rest of the covered services you get as a member of our plan. This includes x-rays, laboratory tests, therapies, care from doctors who are specialists, hospital admissions, and follow-up care.

“Coordinating” your services includes checking or consulting with other network providers about your care and how it is progressing. In some cases, your PCP will need to get prior

Chapter 3 Using the plan for your medical services

authorization (prior approval) from us. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office. Chapter 8 Section 1.4 tells you how we will protect the privacy of your medical records and personal health information.

How do you choose your PCP?

Upon enrollment, you can choose a PCP by selecting a PCP listed in the Provider Directory, or by obtaining assistance from Member Services.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP.

To change your PCP, call Member Services. When you call, be sure to tell Member Services if you are seeing specialists or getting other covered services that needed your PCP's approval (such as home health services, durable medical equipment (DME) or podiatry routine foot care services). Member Services will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. They will also check to be sure the PCP you want to switch to is accepting new patients. Member Services will change your membership record to show the name of your new PCP and tell you when the change to your new PCP will take effect. They will send you a new membership card that shows your new PCP office unless the change of your PCP is within the same primary care office.

Section 2.2	How to get care from specialists and other network providers
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A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists care for patients with cancer
- Cardiologists care for patients with heart conditions
- Orthopedists care for patients with certain bone, joint, or muscle conditions

When your PCP thinks that you need specialized treatment, he/she will recommend that you see a plan specialist or certain other providers. Your PCP will help you arrange or coordinate covered services you get from other plan providers.

For some types of services and care, your provider may need to get approval in advance from our plan (this is called "prior authorization"). Services that need prior authorization are identified in the Benefits Chart in Chapter 4, Section 2.1 by statements in ***bold italics***. You are responsible for making sure that your provider has obtained prior authorization from the plan before you receive any care or services that require it.

What if a specialist or another network provider leaves our plan?

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. If your doctor or specialist leaves your plan you have certain rights and protections that are 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.
- We will make a good faith effort to 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, we will work with you to ensure that the medically necessary treatment you are receiving is not interrupted.
- If our network does not have a qualified specialist for a plan-covered service, we must cover that service at in-network cost sharing.
- 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 to manage your care.
- 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 a quality-of-care complaint to the QIO, a quality-of-care grievance to the plan, or both. Please see Chapter 9.

Section 2.3	How to get care from out-of-network providers
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In certain situations, it may be necessary for you to obtain care outside of the plan's network. You do not need permission from the plan (called prior authorization) to seek out-of-network emergency or urgently needed services, **but for all other types of care, you are responsible for making sure that prior authorization has been obtained before you receive out-of-network care.**

Except for emergency and urgently needed services, we will not pay for out-of-network care you receive without first obtaining prior authorization. To ask for prior authorization, please call the Member Services phone number listed on the back of your Geisinger Gold membership card.

- Our plan covers emergency care or urgently needed services that you obtain from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter. You do not need prior authorization to seek emergency or urgently needed services out-of-network. If you get emergency or urgently needed services out-of-network, your cost is the same cost you would pay in-network for the same service.

Chapter 3 Using the plan for your medical services

- If you need medical care that Medicare requires our plan to cover and an in-network provider cannot provide this care, you can get this care from an out-of-network provider. **Authorization must be obtained from the plan prior to seeking this type of out-of-network care.** In this situation, you will pay the same as you would pay if you got the care from a network provider.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.
- Routine and Medicare-covered eyewear (prescription eyeglasses or contact lenses) benefits may be obtained out of network. Prior authorization to go out of network for eyewear is not necessary.
- Supplemental dental benefits, up to your plan's allowed benefit maximum, **can** be provided by a participating provider **OR** any licensed dentist. For more information, see your new 2023 membership card or contact Member Services.

SECTION 3 How to get services when you have an emergency or urgent need for care or during a disaster

Section 3.1 Getting care if you have a medical emergency
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What is a “medical emergency” and what should you do if you have one?

A “**medical emergency**” is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent your loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval first from your PCP. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they are not part of our network.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. The number to call is on the back of your Geisinger Gold membership card.

Chapter 3 Using the plan for your medical services

What is covered if you have a medical emergency?

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was *not* an emergency, we will cover additional care *only* if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- – *or* – The additional care you get is considered “urgently needed services” and you follow the rules for getting this urgent care (for more information about this, see Section 3.2 below).

Section 3.2	Getting care when you have an urgent need for services
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What are “urgently needed services”?

An urgently needed service is a non-emergency situation requiring immediate medical care, but given your circumstances, it is not possible or not reasonable to obtain these services from a network provider. The plan must cover urgently needed services provided out-of-network. Some examples of urgently needed services are 1) a severe sore throat that occurs over the weekend or 2) an unforeseen flare-up of a known condition when you are temporarily outside the service area.

If you are in the plan's service area and have an urgent need for services, you should contact your PCP's office first, if possible. Many primary care providers reserve some time each day to see patients with an urgent need for services. Even after hours, your PCP may be able to assist you, or may be able to direct you to a partnering in-network provider who is on call for urgent after-hours services. You may also call our 24-hour nurse line, Tel-a-nurse, for assistance at 877-543-

Chapter 3 Using the plan for your medical services

5061. If your PCP and other network providers are unavailable or inaccessible, our plan will cover urgently needed services that you receive at an urgent care center or from an out-of-network provider.

Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances:

If an urgent need for medical services occurs while you are traveling outside the United States, your Geisinger Gold Worldwide Emergency/Urgent Coverage benefit will cover urgently needed services you receive outside of the United States and its territories. Coverage is limited to services that would be classified as urgently needed services had you received them inside the United States, up to a combined Worldwide Emergency/Urgent Coverage benefit limit of \$100,000 per year. Our plan does not cover non-emergency/non-urgent services if you receive the care outside of the United States.

For more information, please see the Worldwide emergency/urgent coverage section of the Benefit Chart in Chapter 4 or contact Member Services.

Section 3.3	Getting care during a disaster
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If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from your plan.

Please visit the following website: www.GeisingerGold.com for information on how to obtain needed care during a disaster.

If you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5 for more information.

SECTION 4	What if you are billed directly for the full cost of your services?
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Section 4.1	You can ask us to pay our share of the cost for covered services
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Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Geisinger Gold Secure Rx (HMO D-SNP) Medicare-covered benefits. **Geisinger Gold is not allowed to reimburse members for Pennsylvania Medical Assistance (Medicaid) covered benefits.**

Chapter 3 Using the plan for your medical services

If you have paid for your covered services, or if you have received a bill for covered medical services, go to Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*) for information about what to do.

Section 4.2 What should you do if services are not covered by our plan?

Geisinger Gold Secure Rx (HMO D-SNP) covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan or services obtained out-of-network and were not authorized, you are responsible for paying the full cost of services.

However, in addition to the **Medicare** Benefits described in this Evidence of Coverage document, you may also have **Pennsylvania Medical Assistance (Medicaid)** benefits that cover some services, drugs and other items that are not covered by your Geisinger Gold Secure Rx (HMO D-SNP) Plan. Before paying for services that are not covered by Geisinger Gold Secure Rx (HMO D-SNP), you will want to check with Pennsylvania Medical Assistance (Medicaid) or your Community HealthChoices Plan to see if the services are covered. You can find phone numbers in Chapter 2, Section 6 of this document. **If you have received services that are not covered by either Geisinger Gold Secure Rx (HMO D-SNP) or by your Pennsylvania Medical Assistance (Medicaid) benefits, you are responsible for paying the full cost of these services.**

Geisinger Gold is not allowed to reimburse members for Pennsylvania Medical Assistance (Medicaid) covered benefits. If you have questions, please contact Member Services.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. You also have the right to ask for this in writing. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service. Costs you have paid once a benefit limit has been reached will not count toward an out-of-pocket maximum. You can call Member Services when you want to know how much of your benefit limit you have already used.

SECTION 5 How are your medical services covered when you are in a “clinical research study”?

Section 5.1 What is a “clinical research study”?

A clinical research study (also called a “clinical trial”) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research

Chapter 3 Using the plan for your medical services

studies are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in the study.

Once Medicare approves the study, and you express interest, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. If you tell us that you are in a qualified clinical trial, then you are only responsible for the in-network cost sharing for the services in that trial. If you paid more, for example, if you already paid the Original Medicare cost-sharing amount, we will reimburse the difference between what you paid and the in-network cost sharing. However, you will need to provide documentation to show us how much you paid. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in any Medicare-approved clinical research study, you do *not* need to tell us or to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

Your Pennsylvania Medical Assistance (Medicaid) benefits may provide additional coverage of services that are not covered by your Medicare benefits. For more information about your Pennsylvania Medical Assistance (Medicaid) benefits, please contact the Pennsylvania Medical Assistance (Medicaid) office at 1-800-642-7462 or your Local County Assistance Office. (Contact information is listed in Chapter 2, section 6 of this document.) You may also contact your Community HealthChoices Provider.

If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study.*

Section 5.2	When you participate in a clinical research study, who pays for what?
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Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you receive as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study
- An operation or other medical procedure if it is part of the research study

Chapter 3 Using the plan for your medical services

- Treatment of side effects and complications of the new care

After Medicare has paid its share of the cost for these services, our plan will pay the rest. For all covered services, you will pay nothing for the covered services you get in the clinical research study. After Medicare has paid its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan. However, you are required to submit documentation showing how much cost sharing you paid. Please see Chapter 7 for more information for submitting requests for payments. If at any time during the benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you are responsible to pay the provider the portion of the cost sharing that Pennsylvania Medical Assistance (Medicaid) would have otherwise paid on your behalf.

Here's an example of how the cost sharing works: Let's say that you have a lab test that costs \$100 as part of the research study. Let's also say that your share of the costs for this test is \$20 under Original Medicare, but the test would be \$10 under our plan's benefits. In this case, Original Medicare would pay \$80 for the test and you would pay the \$20 copay required under Original Medicare. You would then notify your plan that you received a qualified clinical trial service and submit documentation such as a provider bill to the plan. The plan would then directly pay you \$10. Therefore, your net payment is \$10, the same amount you would pay under our plan's benefits. Please note that in order to receive payment from your plan, you must submit documentation to your plan such as a provider bill.

When you are part of a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication "Medicare and Clinical Research Studies." (The publication is available at: www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf.) You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 6 Rules for getting care in a “religious non-medical health care institution”

Section 6.1	What is a religious non-medical health care institution?
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A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member’s religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2	Receiving Care From a Religious Non-Medical Health Care Institution
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To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is “non-excepted.”

- “Non-excepted” medical care or treatment is any medical care or treatment that is *voluntary* and *not required* by any federal, state, or local law.
- “Excepted” medical treatment is medical care or treatment that you get that is *not* voluntary or *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan’s coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
 - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
 - – *and* – You must get approval in advance from our plan before you are admitted to the facility, or your stay will not be covered.
 - Original Medicare inpatient hospital coverage limits apply.
 - For more information about our plan’s coverage of services, please see the Benefit Chart in Chapter 4

For information about additional services which may be covered by your Pennsylvania Medical Assistance (Medicaid) benefits or Medicare cost sharing paid by Pennsylvania Medical Assistance (Medicaid) on your behalf, please contact the Pennsylvania Medical Assistance

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(Medicaid) office at 1-800-642-7462, your Community HealthChoices Plan or your local County Assistance Office. (Contact information is listed in Chapter 2, Section 6 of this document.)

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1	Will you own the durable medical equipment after making a certain number of payments under our plan?
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Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of Geisinger Gold Secure Rx (HMO D-SNP), however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under certain limited circumstances, we will transfer ownership of the DME item to you. Call member services for more information.

Your Pennsylvania Medical Assistance (Medicaid) benefits may provide additional coverage of DME items and services that are not covered by your Medicare benefits. For more information about your Pennsylvania Medical Assistance (Medicaid) benefits, please contact the Pennsylvania Medical Assistance (Medicaid) office at 1-800-642-7462, your Community HealthChoices Plan or your Local County Assistance Office. (Contact information is listed in Chapter 2, Section 6 of this document.)

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. The payments made while enrolled in our plan do not count.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare do not count.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You were in our plan but did not obtain ownership while in our plan. You then go back to Original Medicare. You will have to make 13 consecutive new payments to own the item once you join Original Medicare again. All previous payments (whether to our plan or to Original Medicare) do not count.

Section 7.2	Rules for oxygen equipment, supplies, and maintenance
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What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage Geisinger Gold Secure Rx (HMO D-SNP) will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave Geisinger Gold Secure Rx (HMO D-SNP) or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

What happens if you leave our plan and return to Original Medicare?

Original Medicare requires an oxygen supplier to provide you services for five years. During the first 36 months you rent the equipment. The remaining 24 months the supplier provides the equipment and maintenance (you are still responsible for the cost-sharing for oxygen). After five years you may choose to stay with the same company or go to another company. At this point, the five-year cycle begins again, even if you remain with the same company, requiring you to pay cost-sharing for the first 36 months. If you join or leave our plan, the five-year cycle starts over.

CHAPTER 4:

Medical Benefits Chart (what is covered)

SECTION 1 Understanding your out-of-pocket costs for covered services

This chapter provides a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of Geisinger Gold Secure Rx (HMO D-SNP). Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services. If at any time during the benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you are responsible to pay the provider the portion of the cost sharing that Pennsylvania Medical Assistance (Medicaid) would have otherwise paid on your behalf.

Section 1.1 You pay nothing for your covered services
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Because you get assistance from Pennsylvania Medical Assistance (Medicaid), you pay nothing for your covered services as long as you follow the plans' rules for getting your care. (See Chapter 3 for more information about the plans' rules for getting your care.)

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- The **“deductible”** is the amount you must pay for medical services before our plan begins to pay its share. (Section 1.2 tells you more about your plan deductible.) (Section 1.3 tells you more about your deductibles for certain categories of services.)
- A **“copayment”** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **“Coinsurance”** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

Depending on your level of Medical Assistance Benefit, Pennsylvania Medical Assistance (Medicaid) may require certain Geisinger Gold Secure Rx (HMO D-SNP) members to pay Pennsylvania Medical Assistance (Medicaid) copayments when receiving covered services. For more information about your Pennsylvania Medical Assistance (Medicaid) Benefit, please contact the Pennsylvania Medical Assistance (Medicaid) Office at 1-800-642-7462 or your Local County Assistance Office. See Chapter 2, section 6 for Pennsylvania Medical Assistance (Medicaid) contact information. You may also contact your Community HealthChoices Plan.

Section 1.2	What is the most you will pay for Medicare Part A and Part B covered medical services?
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Note: Because our members also get assistance from Pennsylvania Medical Assistance (Medicaid), very few members ever reach this out-of-pocket maximum. If you are eligible for Medicare cost-sharing assistance under Pennsylvania Medical Assistance (Medicaid), you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

Because you are enrolled in a Medicare Advantage Plan, there is a limit on the amount you have to pay out-of-pocket each year for medical services that are covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. For calendar year 2023 this amount is \$7,550.

The amounts you pay for copayments, and coinsurance for covered services count toward this maximum out-of-pocket amount. The amounts you pay for your Part D late enrollment penalty and for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of \$7,550, you will not have to pay any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3	Our plan does not allow providers to “balance bill” you
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As a member of Geisinger Gold Secure Rx (HMO D-SNP), an important protection for you is that you only have to pay your cost-sharing amount when you get services covered by our plan. Providers may not add additional separate charges, called “balance billing.” This protection applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don’t pay certain provider charges.

Here is how this protection works.

- If your cost sharing is a copayment (a set amount of dollars, for example, \$15.00), then you pay only that amount for any covered services from a network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
 - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan’s reimbursement rate (as determined in the contract between the provider and the plan).

Chapter 4 Medical Benefits Chart (what is covered)

- If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get an authorization or for emergencies or urgently needed services.)
- If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get an authorization, or for emergencies or urgently needed services.)
- If you believe a provider has “balance billed” you, call Member Services.

SECTION 2 Use the *Medical Benefits Chart* to find out what is covered

Section 2.1	Your medical benefits as a member of the plan
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The Medical Benefits Chart on the following pages lists the services Geisinger Gold Secure Rx (HMO D-SNP) covers. Part D prescription drug coverage is in Chapter 5. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) *must* be medically necessary. “Medically necessary” means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered unless it is emergent or urgent care or unless your plan or a network provider has given you authorization. This means that you will have to pay the provider in full for the services furnished.
- You have a primary care provider (a PCP) who is providing and overseeing your care.
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called “prior authorization”) from us. Covered services that need approval in advance are marked in the Medical Benefits Chart in **bold italics**. In addition, the following services not listed in the Benefits Chart require prior authorization:
 - Biofeedback Training
- We may also charge you "administrative fees" for missed appointments. Call Member Services if you have questions regarding these administrative fees.

Other important things to know about our coverage:

- You are covered by both Medicare and Pennsylvania Medical Assistance (Medicaid). Medicare covers health care and prescription drugs. Pennsylvania Medical Assistance (Medicaid) covers your cost sharing for Medicare services, including Medicare Part A and B deductibles, copayments, and coinsurance. Pennsylvania Medical Assistance (Medicaid) also covers services Medicare does not cover, like *long-term care, and home and community-based services*.
- Like all Medicare health plans, we cover everything that Original Medicare covers. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2023* handbook. View it online at www.medicare.gov or ask for 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.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you.
- If Medicare adds coverage for any new services during 2023, either Medicare or our plan will cover those services.
- If you are within our plan's 6-month period of deemed continued eligibility, we will continue to provide all Medicare Advantage plan-covered Medicare benefits. However, during this period, we will *not* pay the Medicare premiums or cost sharing for which the state would otherwise be liable had you not lost your Pennsylvania Medical Assistance (Medicaid) eligibility. Medicare cost-sharing amounts for Medicare basic and supplemental benefits do not change during this period.

If you are eligible for Medicare cost-sharing assistance under Pennsylvania Medical Assistance (Medicaid), you do not pay anything for the services listed in the Benefits Chart, as long as you meet the coverage requirements described above.

Important Benefit Information for all Enrollees Participating in Wellness and Health Care Planning (WHP) Services

- Because Geisinger Gold Secure Rx (HMO D-SNP) participates in the Value Based Insurance Design program, you will be eligible for the following WHP services, including advance care planning (ACP) services:
- Each member is contacted, at minimum annually, to complete a health risk assessment and create a care plan based on their individualized identified medical, behavioral, and social needs. This includes evaluating where the member is in the process of establishing an advanced care plan and assisting in connecting with resources to develop and implement an appropriate plan. Participation by the member is voluntary and can decline at any time. If a member decides at a future date to participate, they will be provided with direct contact information from their assigned case manager. We will also reach out to the member in the event of change in condition and/or annually.

- The member can access Wellness and Health Care Planning services by connecting with their assigned case manager at their dedicated phone number or contacting Member Services.

Important Benefit Information for Enrollees Who Qualify for “Extra Help”:

- If you receive “Extra Help” to pay your Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance, you may be eligible for other targeted supplemental benefits and/or targeted reduced cost sharing.
- Please go to the Medical Benefits Chart in Chapter 4 for further detail.
- You may qualify for a reduction or elimination of your cost sharing for Part D drugs in Chapter 6, Section 2.1

Important Benefit Information for Enrollees with Chronic Conditions

- If you are diagnosed with the following chronic condition(s) identified below and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill.
 1. Chronic alcohol and other drug dependence;
 2. Autoimmune disorders limited to:
 - Polyarteritis nodosa,
 - Polymyalgia rheumatica,
 - Polymyositis,
 - Rheumatoid arthritis, and
 - Systemic lupus erythematosus;
 3. Cancer, excluding pre-cancer conditions or in-situ status;
 4. Cardiovascular disorders limited to:
 - Cardiac arrhythmias,
 - Coronary artery disease,
 - Peripheral vascular disease, and
 - Chronic venous thromboembolic disorder;
 5. Chronic heart failure;
 6. Dementia;
 7. Diabetes mellitus;
 8. End-stage liver disease;
 9. End-stage renal disease (ESRD) requiring dialysis;
 10. Severe hematologic disorders limited to:
 - Aplastic anemia,
 - Hemophilia,
 - Immune thrombocytopenic purpura,
 - Myelodysplastic syndrome,
 - Sickle-cell disease (excluding sickle-cell trait), and
 - Chronic venous thromboembolic disorder;
 11. HIV/AIDS;
 12. Chronic lung disorders limited to:
 - Asthma,
 - Chronic bronchitis,

- Emphysema,
 - Pulmonary fibrosis, and
 - Pulmonary hypertension;
13. Chronic and disabling mental health conditions limited to:
- Bipolar disorders,
 - Major depressive disorders,
 - Paranoid disorder,
 - Schizophrenia, and
 - Schizoaffective disorder;
14. Neurologic disorders limited to:
- Amyotrophic lateral sclerosis (ALS),
 - Epilepsy,
 - Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia),
 - Huntington’s disease,
 - Multiple sclerosis,
 - Parkinson’s disease,
 - Polyneuropathy,
 - Spinal stenosis, and
 - Stroke-related neurologic deficit; and
15. Stroke.
- Plan representatives and Plan Care staff will verify member eligibility and assess each individual’s disease state, treatment plan, and relevant social determinants to validate any supplemental benefits provided will have reasonable impact toward maintaining or improving a member’s unique health status.
 - As part of this SSBCI benefit, members who meet the eligibility criteria must receive pre-approval for any qualified benefit(s) by the Plan’s care staff, and the pre-approved benefit(s) will be subject to the total annual benefit maximum.
 - Please go to the “Special Supplemental Benefits for the Chronically Ill” row in the below Medical Benefits Chart for further detail.
 - Please contact us to find out exactly which benefits you may be eligible for.

 You will see this apple next to the preventive services in the benefits chart. Medicare covers many of these preventive services at no cost to members. To determine which preventive benefits are covered with \$0 cost sharing and which have a copayment or coinsurance, please see the cost sharing listed in the Benefit Chart for each benefit.

Medical Benefits Chart

Benefits that require prior authorization are identified in the table below by a prior authorization statement in ***bold italics***.

Amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with an asterisk (*) in the Medical Benefits Chart.

Services that are covered for you	What you must pay when you get these services
<p> Abdominal aortic aneurysm screening</p> <p>A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get an order for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.</p>	<p>There is no coinsurance, copayment, or deductible for members eligible for this in-network Medicare-covered preventive screening.</p>
<p>Acupuncture for chronic low back pain</p> <p>Covered services include:</p> <p>Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances:</p> <p>For the purpose of this benefit, chronic low back pain is defined as:</p> <ul style="list-style-type: none"> • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); • not associated with surgery; and • not associated with pregnancy. <p>An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.</p> <p>Treatment must be discontinued if the patient is not improving or is regressing.</p> <p>Provider Requirements:</p> <p>Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements.</p> <p>Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they</p>	<p>0% Coinsurance for in-network Medicare-covered acupuncture for chronic low back pain services.</p> <p>Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Medicare-covered services you receive.</p> <p>If at any time during the benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you will be given a 6-month grace period to get your Pennsylvania Medical Assistance (Medicaid) eligibility back. During this 6-month grace period, <i>you</i> are responsible for paying the 20% coinsurance to the provider for the portion of the cost sharing that Pennsylvania</p>

Services that are covered for you	What you must pay when you get these services
<p>meet all applicable state requirements and have:</p> <ul style="list-style-type: none"> • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. <p>Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.</p>	<p>Medical Assistance (Medicaid) would have otherwise paid on your behalf.</p>
<p>Ambulance services</p> <p>Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person’s health or if authorized by the plan.</p> <p>Non-emergency transportation by ambulance is appropriate if it is documented that the member’s condition is such that other means of transportation could endanger the person’s health and that transportation by ambulance is medically required.</p> <p>Medicare-covered non-emergency transportation by ambulance must be obtained from an in-network ambulance service.</p> <p><i>Prior Authorization is required for non-emergency transportation by ambulance. The ambulance provider must contact our plan before providing services.</i></p> <p>(See Worldwide emergency/urgent coverage section of this Benefit Chart for the worldwide emergency transportation benefit)</p> <p>Please contact Member Services for more details</p>	<p>0% Coinsurance for Medicare-covered ambulance services.</p> <p>Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Medicare-covered services you receive.</p> <p>If at any time during the benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you will be given a 6-month grace period to get your Pennsylvania Medical Assistance (Medicaid) eligibility back. During this 6-month grace period, <i>you</i> are responsible for paying the 20% coinsurance to the provider for the portion of the cost sharing that Pennsylvania Medical Assistance (Medicaid) would have otherwise paid on your behalf.</p>

Services that are covered for you	What you must pay when you get these services
<p>Annual Routine Physical Examination</p> <p>The supplemental Annual Routine Physical is a comprehensive hands-on physical examination covered once each calendar year. It includes a routine examination of the eyes, ears, head, neck, abdomen and extremities, and cardiovascular, pulmonary, and neurological bodily systems.</p> <p>The exam also includes a review of your prescription medicines, and if needed, your provider may order lab or diagnostic tests. (See the outpatient diagnostic test section in this table for more information.)</p>	<p>\$0 Copayment for in-network annual routine physical examination.</p>
<p> Annual wellness visit</p> <p>If you've had Medicare Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every calendar year.</p> <p>Note: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.</p>	<p>There is no coinsurance, copayment, or deductible for the in-network Medicare-covered annual wellness visit.</p>
<p> Bone mass measurement</p> <p>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered once every two calendar years or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.</p>	<p>There is no coinsurance, copayment, or deductible for in-network Medicare-covered bone mass measurement.</p>
<p> Breast cancer screening (mammograms)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> One baseline mammogram between the ages of 35 and 39 One screening mammogram each calendar year for women age 40 and older Clinical breast exams once every two calendar years 	<p>There is no coinsurance, copayment, or deductible for in-network Medicare-covered screening mammograms.</p>

Services that are covered for you	What you must pay when you get these services
<p>Cardiac rehabilitation services</p> <p>Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor’s order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p> <p><i>Prior Authorization is required. Your provider must contact our Plan prior to providing services.</i></p>	<p>0% Coinsurance for in-network Medicare-covered Cardiac Rehabilitation services.</p> <p>Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Medicare-covered services you receive.</p> <p>If at any time during the benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you will be given a 6-month grace period to get your Pennsylvania Medical Assistance (Medicaid) eligibility back. During this 6-month grace period, <i>you</i> are responsible for paying the 20% coinsurance to the provider for the portion of the cost sharing that Pennsylvania Medical Assistance (Medicaid) would have otherwise paid on your behalf.</p>
<p> Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</p> <p>We cover one visit per calendar year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you’re eating healthy.</p> <p>The cardiovascular disease risk reduction visit must be with a primary care provider.</p>	<p>There is no coinsurance, copayment, or deductible for the in-network Medicare-covered intensive behavioral therapy cardiovascular disease preventive benefit.</p>

Services that are covered for you	What you must pay when you get these services
<p> Cardiovascular disease testing</p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months)</p>	<p>There is no coinsurance, copayment, or deductible for in-network Medicare-covered cardiovascular disease testing that is covered once every 5 years.</p>
<p> Cervical and vaginal cancer screening</p> <p>Covered services include:</p> <p>For all women: Pap tests and pelvic exams are covered once every two calendar years</p> <p>If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test and pelvic exam every calendar year</p>	<p>There is no coinsurance, copayment, or deductible for in-network Medicare-covered preventive Pap and pelvic exams.</p>
<p>Chiropractic services</p> <p>Covered services include:</p> <p>We cover only manual manipulation of the spine to correct subluxation</p>	<p>0% Coinsurance for in-network Medicare-covered Chiropractic services.</p> <p>Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Medicare-covered services you receive.</p> <p>If at any time during the benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you will be given a 6-month grace period to get your Pennsylvania Medical Assistance (Medicaid) eligibility back. During this 6-month grace period, <i>you</i> are responsible for paying the 20% coinsurance to the provider for the portion of the cost</p>

Services that are covered for you	What you must pay when you get these services
	<p>sharing that Pennsylvania Medical Assistance (Medicaid) would have otherwise paid on your behalf.</p>
<p> Colorectal cancer screening</p> <p>For people 50 and older, the following are covered:</p> <ul style="list-style-type: none"> • Flexible sigmoidoscopy (or screening barium enema as an alternative) once every four calendar years <p>One of the following once each calendar year:</p> <ul style="list-style-type: none"> • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) <p>DNA based colorectal screening once each three calendar years</p> <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy (or screening barium enema as an alternative) once every two calendar years <p>For people not at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy 	<p>There is no coinsurance, copayment, or deductible for an in-network Medicare-covered colorectal cancer screening exam.</p>
<p>Dental services</p> <p>In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover:</p> <p>Supplemental Dental Services</p> <p>Geisinger Gold Secure Rx (HMO D-SNP) covers any combination of the following dental services each year, up to the annual supplemental dental services benefit limit:</p> <ul style="list-style-type: none"> • Routine Oral exams, up to two (2) visits every year • Routine cleanings, up to two (2) visits every year • Fluoride treatment, up to two (2) visits per year • Dental x-rays two (2) visits per year • Fillings • Simple extractions • Crowns • Non-surgical periodontic services for treatment of gum disease 	<p>\$0 Copayment for covered supplemental dental services up to the combined \$4,500 annual supplemental dental services benefit limit.</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none">• Root Canals• Dentures <p>Non-Medicare-covered supplemental dental benefits, up to your plan's allowed benefit maximum, can be provided by a participating provider OR any licensed dentist. For more information, see your new 2023 member ID card or contact Member Services.</p> <p>*The Non-Medicare-covered supplemental dental services listed in this section do not count toward the plan out-of-pocket maximum.</p> <p>Medicare-covered Dental Services</p> <p>Generally, Medicare-covered dental services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician</p> <p>Medicare-covered dental services must be provided by an in-network dental provider.</p> <p><i>Prior Authorization is required. Your provider must contact our Plan prior to providing services.</i></p>	<p>0% Coinsurance for in-network Medicare-covered dental services.</p> <p>Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Medicare-covered services you receive.</p> <p>If at any time during the benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you will be given a 6-month grace period to get your Pennsylvania Medical Assistance (Medicaid) eligibility back. During this 6-month grace period, <i>you</i> are responsible for paying the 20% coinsurance to the provider for the portion of the cost sharing that Pennsylvania Medical Assistance (Medicaid) would have otherwise paid on your behalf.</p>

Services that are covered for you	What you must pay when you get these services
<p> Depression screening</p> <p>We cover one screening for depression per calendar year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.</p>	<p>There is no coinsurance, copayment, or deductible for an in-network Medicare-covered annual depression screening visit.</p>
<p> Diabetes screening</p> <p>We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.</p> <p>Based on the results of these tests, you may be eligible for up to two diabetes screenings each calendar year.</p>	<p>There is no coinsurance, copayment, or deductible for the in-network Medicare-covered diabetes screening tests.</p>
<p>Diabetes self-management training, diabetic services and supplies</p> <p> Diabetes self-management training</p> <ul style="list-style-type: none"> Diabetes self-management training is covered under certain conditions <p>Diabetes services and supplies</p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. This is not a preventive service; cost sharing may apply. For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. This is not a preventive service; 	<p>There is no coinsurance, copayment, or deductible for in-network Medicare-covered diabetes self-management training.</p> <p>0% Coinsurance for in-network Medicare-covered preferred-brand glucometer.</p> <p>0% Coinsurance for in-network Medicare-covered diabetes testing supplies, including meters, test strips, non-preferred brand glucometers and lancets.</p> <p>0% Coinsurance for in-network Medicare-covered continuous glucose monitors for people who use insulin and meet the medical</p>

Services that are covered for you	What you must pay when you get these services
<p>cost sharing may apply.</p> <p><i>Prior Authorization is required for more than 200 test strips per month, non-preferred brand glucometers and non-preferred brand test strips. Your provider must contact our Plan prior to providing services.</i></p> <p><i>Preferred Brand Glucometers are limited to one every two years, unless prior authorization is obtained</i></p> <p>Continuous Glucose Monitors <i>may</i> be covered by Medicare for people who use insulin and meet the medical necessity criteria.</p>	<p>necessity criteria may be covered.</p> <p>0% Coinsurance for in-network Medicare-covered therapeutic shoes or inserts for people with severe diabetic foot disease.</p> <p>Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Medicare-covered items and services you receive.</p> <p>If at any time during the benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you will be given a 6-month grace period to get your Pennsylvania Medical Assistance (Medicaid) eligibility back. During this 6-month grace period, <i>you</i> are responsible for paying the 20% coinsurance to the provider for the portion of the cost sharing that Pennsylvania Medical Assistance (Medicaid) would have otherwise paid on your behalf.</p>
<p>Durable medical equipment (DME) and related supplies (For a definition of “durable medical equipment,” see Chapter 12 as well as Chapter 3, Section 7 of this document.)</p> <p>Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion</p>	<p>0% Coinsurance for in-network Medicare-covered Durable Medical Equipment and related supplies.</p> <p>Your cost sharing for Medicare oxygen equipment coverage is 0% Coinsurance,</p>

Services that are covered for you	What you must pay when you get these services
<p>pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.</p> <p>We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.GeisingerGold.com. Durable Medical Equipment (DME) & supplies are managed and fulfilled by a Geisinger Gold Vendor. Members can visit the website at home.TomorrowHealth.com/ghp or call 844-402-4344 to place or track their order status.</p> <p><i>Prior Authorization is required. Your provider must contact our Plan prior to providing services.</i></p> <p>Please see the previous section in this table for more information about Plan coverage of diabetic supplies.</p>	<p>every month.</p> <p>If prior to enrolling in Geisinger Gold Secure Rx (HMO D-SNP) you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in Geisinger Gold Secure Rx (HMO D-SNP) is 0% Coinsurance</p> <p>Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Medicare-covered items and services you receive.</p> <p>If at any time during the benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you will be given a 6-month grace period to get your Pennsylvania Medical Assistance (Medicaid) eligibility back. During this 6-month grace period, <i>you</i> are responsible for paying the 20% coinsurance to the provider for the portion of the cost sharing that Pennsylvania Medical Assistance (Medicaid) would have otherwise paid on your behalf.</p>

Services that are covered for you	What you must pay when you get these services
<p>Emergency care</p> <p>Emergency care refers to services that are:</p> <ul style="list-style-type: none">• Furnished by a provider qualified to furnish emergency services, and• Needed to evaluate or stabilize an emergency medical condition. <p>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.</p> <p>Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.</p> <p>(See Worldwide emergency/urgent coverage section of this Benefit Chart for the worldwide emergency services benefit)</p> <p>Please contact Member Services for more details.</p>	<p>\$0 Copayment for Medicare-covered emergency care.</p> <p>Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Medicare-covered services you receive.</p> <p>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost sharing you would pay at a network hospital.</p> <p>If at any time during the benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you will be given a 6-month grace period to get your Pennsylvania Medical Assistance (Medicaid) eligibility back. During this 6-month grace period, <i>you</i> are responsible for paying the \$95 copayment to the provider for the portion of the cost sharing that Pennsylvania Medical Assistance (Medicaid) would have otherwise paid on your behalf.</p>

Services that are covered for you	What you must pay when you get these services
<p> Health and wellness education programs</p> <p>Fitness benefit</p> <p>*To promote exercise, health and wellness, and staying active, Geisinger Gold will pay up to a combined maximum benefit limit every calendar quarter towards the purchase of a fitness center membership. This benefit includes coverage of a membership to a gym, fitness center, or exercise facility of your choice or fees for certain fitness/exercise classes.</p> <p>The following services are not covered:</p> <ul style="list-style-type: none">• Personal trainers• In-home exercise coaches <p>If you have any questions regarding the combined maximum Fitness benefit (covered every calendar quarter), please contact Member Services or by logging in at www.GeisingerGold.com</p> <p>Tel-a-Nurse Nurseline</p> <p>Tel-A-Nurse Phone: 877-543-5061 Calls to this number are free.</p> <p>Tel-A-Nurse hours are 24 hours a day, seven days a week</p> <p>The Tel-A-Nurse nurse line provides plan members with health and wellness advice and information by telephone, toll-free, 24 hours per day, 365 days per year or via live chat online, 24 hours per day. Members may speak to a registered nurse at any time to obtain general information on all types of non-emergency health and medical conditions. An audio library is also available by calling the Tel-A-Nurse toll-free phone number. This library is a compilation of recorded advice on many health topics, like viral infections, nutrition, and more.</p> <p>Other Health Management and Wellness Services</p> <p>Geisinger Gold health management programs offer support for chronic medical conditions, such as diabetes, hypertension, heart failure, COPD and asthma. Our health managers provide personalized care, education, and guidance for members with</p>	<p>\$120 calendar quarter fitness benefit allowance toward combined membership fees at a gym, fitness center, or exercise facility of your choice or fees for certain fitness/exercise classes.</p> <p>There is no charge for calling the Tel-A-Nurse line.</p> <p>These services are Geisinger Health Plan wellness programs and are available at no cost to all Geisinger</p>

Services that are covered for you	What you must pay when you get these services
<p>chronic health conditions. They also work in partnership with doctors to develop a personalized plan of care to help you prevent disease and disability and stay healthier.</p> <p>Other wellness tools are also available to help you meet your health goals. Additional information about our other wellness services and tools are available by logging in at www.GeisingerGold.com.</p>	<p>Gold Members.</p> <p>Please contact Member Services.</p>
<p>Hearing services</p> <p>Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.</p> <p>The following hearing services are covered:</p> <ul style="list-style-type: none"> • One (1) routine hearing exam per calendar year, performed by a physician, audiologist, or other qualified provider • Other diagnostic procedures performed by a physician, audiologist or other qualified provider. For more information, please see the benefit and cost sharing information for Outpatient Diagnostic Tests in this chart. • A basic hearing evaluation may also be included in your annual wellness visit; ask your PCP. <p>Covered hearing aid services are managed by a designated vendor. Hearing aid providers must be in the designated vendor’s network. For more information about finding hearing aid providers that participate in the vendor network, please call Member Services.</p> <p>*Hearing aids and hearing aid fitting evaluations do not count toward plan out-of-pocket maximum.</p>	<p>0% Coinsurance for in-network Medicare-covered diagnostic hearing exams.</p> <p>Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Medicare-covered services you receive.</p> <p>If at any time during the benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you will be given a 6-month grace period to get your Pennsylvania Medical Assistance (Medicaid) eligibility back. During this 6-month grace period, <i>you</i> are responsible for paying the 20% coinsurance to the provider for the portion of the cost sharing that Pennsylvania Medical Assistance (Medicaid) would have otherwise paid on your behalf.</p> <p>\$0 Copayment for in-network routine hearing exam, covered once per</p>

Services that are covered for you	What you must pay when you get these services
	<p>calendar year.</p> <p>*\$2,950 allowance per ear, every three years for two hearing aids including hearing aid testing and fitting done by a hearing aid provider up to the maximum annual benefit limit.</p>
<p> HIV screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> • One screening exam each calendar year <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none"> • Up to three screening exams during a pregnancy 	<p>There is no coinsurance, copayment, or deductible for members eligible for in-network Medicare-covered preventive HIV screening.</p>
<p>Home health agency care</p> <p>Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies <p><i>Prior Authorization is required. Your provider must contact our Plan prior to providing services.</i></p> <p><i>Please refer to the Hospice Care Benefit for information about home health services for members enrolled in the Medicare Hospice Program.</i></p>	<p>\$0 Copayment for in-network Medicare-covered home health agency care.</p> <p>Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Medicare-covered services you receive.</p>

Services that are covered for you	What you must pay when you get these services
<p>Home infusion therapy</p> <p>Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters).</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none">• Professional services, including nursing services, furnished in accordance with the plan of care• Patient training and education not otherwise covered under the durable medical equipment benefit• Remote monitoring• Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier <p><i>Prior Authorization is required. Your provider must contact our Plan prior to providing services.</i></p>	<p>0% Coinsurance for in-network Medicare-covered Durable Medical Equipment and related supplies.</p> <p>Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Medicare-covered items and services you receive.</p> <p>If at any time during the benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you will be given a 6-month grace period to get your Pennsylvania Medical Assistance (Medicaid) eligibility back. During this 6-month grace period, <i>you</i> are responsible for paying the 20% coinsurance to the provider for the portion of the cost sharing that Pennsylvania Medical Assistance (Medicaid) would have otherwise paid on your behalf.</p>
<p>Hospice care</p> <p>You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in.</p>	<p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Geisinger</p>

Services that are covered for you	What you must pay when you get these services
<p>Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Covered services include:</p> <ul style="list-style-type: none">• Drugs for symptom control and pain relief• Short-term respite care• Home care <p><u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> Original Medicare (rather than our plan) will pay your hospice provider for your hospice services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing.</p> <p><u>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:</u> If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization).</p> <ul style="list-style-type: none">• If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost-sharing amount for in-network services• If you obtain the covered services from an out-of-network provider, you pay the cost sharing under Fee-for-Service Medicare (Original Medicare) <p><u>For services that are covered by Geisinger Gold Secure Rx (HMO D-SNP) but are not covered by Medicare Part A or B:</u> Geisinger Gold Secure Rx (HMO D-SNP) will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services.</p> <p><u>For drugs that may be covered by the plan's Part D benefit:</u> If these drugs are unrelated to your terminal hospice condition you pay cost sharing. If they are related to your terminal hospice condition then you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section</p>	<p>Gold Secure Rx (HMO D-SNP).</p>

Services that are covered for you	What you must pay when you get these services
<p>9.3 (<i>What if you're in Medicare-certified hospice</i>).</p> <p>Note: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.</p> <p>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.</p>	<p>\$0 Copayment for one-time only in-network Medicare covered hospice consultation service.</p>
<p> Immunizations</p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none">• Pneumonia vaccine• Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary• Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B• COVID-19 vaccine• Other vaccines if you are at risk and they meet Medicare Part B coverage rules <p>We also cover some vaccines under our Part D prescription drug benefit. Please see Chapter 6, Section 9 for more information.</p>	<p>There is no coinsurance, copayment, or deductible for the in-network Medicare-covered pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.</p>
<p>Inpatient hospital care</p> <p>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.</p> <p>There is no limit to the number of covered days as long as an inpatient level of care is medically necessary.</p> <p><i>Prior Authorization is required for routine or planned hospital admissions and all transplant-related care. Your provider must contact our Plan prior to providing services.</i></p> <p><i>If you are admitted in an emergency or urgent situation, you or someone else should call to tell us about your emergency care, usually within 48 hours. The number to call is on your</i></p>	<p><i>These are 2022 cost sharing amounts and may change for 2023:</i></p> <p>In 2022, you pay:</p> <ul style="list-style-type: none">• \$1,556 deductible for each benefit period• \$0 for the first 60 days for each benefit period• \$389 per day for days 61-90 for each benefit period• \$778 per lifetime reserve day after 91 days for each benefit

Services that are covered for you	What you must pay when you get these services
<p><i>Geisinger Gold membership card.</i></p> <p>Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Geisinger Gold Secure Rx (HMO D-SNP) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. We will reimburse appropriate travel expenses based upon limits set by the GSA/IRS federal per diem rates and travel expense reimbursement rules. *Travel, lodging and meals do not count toward the maximum out-of-pocket cost limits. For information on submitting receipts and the plan’s specific guidelines for travel, lodging and meal reimbursement, please contact Member Services • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the 	<p>period (up to a maximum of 60 days over your lifetime)</p> <p>If you get inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.</p> <p>Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Medicare-covered services you receive.</p> <p>If at any time during the benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you are responsible to pay the provider the portion of the cost sharing that Pennsylvania Medical Assistance (Medicaid) would have otherwise paid on your behalf.</p>

Services that are covered for you	What you must pay when you get these services
<p>fourth pint of blood that you need, you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used.</p> <ul style="list-style-type: none">• Physician services• Care from a religious non-medical health care institution is covered under certain conditions. Original Medicare inpatient hospital coverage limits apply. For more information, please see Chapter 3, Section 6. <p>Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.</p> <ul style="list-style-type: none">• You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	
<p>Inpatient services in a psychiatric hospital</p> <p>Covered services include mental health care services that require a hospital stay. You have a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to mental health services provided in a psychiatric unit of a general hospital.</p> <p>Benefits received prior to enrollment shall be counted toward utilization of your total lifetime limit.</p> <p><i>Prior Authorization is required. Your provider must contact our Plan prior to providing services by contacting the mental health/substance abuse phone number located on the back of your membership card.</i></p>	<p><i>These are 2022 cost sharing amounts and may change for 2023:</i></p> <p>In 2022, you pay:</p> <ul style="list-style-type: none">• \$1,556 deductible for each benefit period• \$0 for the first 60 days for each benefit period• \$389 per day for days 61-90 for each benefit period• \$778 per "lifetime reserve day" after 91 days for each benefit period (up to a

Services that are covered for you	What you must pay when you get these services
	<p>maximum of 60 days over your lifetime)</p> <p>Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Medicare-covered services you receive.</p> <p>If at any time during the benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you are responsible to pay the provider the portion of the cost sharing that Pennsylvania Medical Assistance (Medicaid) would have otherwise paid on your behalf.</p>
<p>Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay</p> <p>If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a 	<p>You pay 100% of inpatient facility charges during a non-covered inpatient stay.</p> <p>Applicable outpatient copayments and/or coinsurance apply to each Medicare-covered service and item you receive during a non-covered inpatient stay.</p> <p>Please see each benefit listed in the Outpatient Services section of this chart for information about covered outpatient services and cost sharing amounts that apply</p>

Services that are covered for you	What you must pay when you get these services
<p>permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices</p> <ul style="list-style-type: none"> • Leg, arm, back, and neck braces; trusses; and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient’s physical condition • Physical therapy, speech therapy, and occupational therapy <p><i>Prior Authorization is required for some outpatient services. Your provider must contact our Plan prior to providing services. Please refer to each benefit section for more information.</i></p>	<p>for each service.</p> <p>Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Medicare-covered services you receive.</p> <p>If at any time during the benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you are responsible to pay the provider the portion of the cost sharing that Pennsylvania Medical Assistance (Medicaid) would have otherwise paid on your behalf.</p>
<p> Medical nutrition therapy</p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor.</p> <p>We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician’s order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.</p>	<p>There is no coinsurance, copayment, or deductible for members eligible for in-network Medicare-covered medical nutrition therapy services.</p>
<p> Medicare Diabetes Prevention Program (MDPP)</p> <p>MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans.</p> <p>MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change,</p>	<p>There is no coinsurance, copayment, or deductible for members eligible for the in-network Medicare-covered</p>

Services that are covered for you	What you must pay when you get these services
<p>increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.</p>	<p>MDPP benefit.</p>
<p>Medicare Part B prescription drugs</p> <p>These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan.</p> <p><i>Medicare Part B prescription drugs require prior authorization and/or step therapy. Your provider must contact our plan.</i></p> <p>Covered drugs include:</p> <ul style="list-style-type: none"> • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases <p>Covered drugs that may be subject to step therapy include, but are not limited to:</p> <ul style="list-style-type: none"> • Erythropoetin Stimulating Agents • Granulocyte Colony Stimulating Factors • Infliximab Agents 	<p>0% Coinsurance for in-network Medicare-covered Part B prescription drugs. Also applies to the administration of the drug.</p> <p>0% Coinsurance for in-network Medicare-covered insulin administered through Durable Medical Equipment (DME) (i.e., insulin pump).</p> <p>0% Coinsurance for all other in-network Medicare-covered Medicare Part B drugs including the administration of the drug. Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Medicare-covered Part B drugs, items, and services you receive.</p> <p>If at any time during the benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you will be given a 6-month grace period to get your Pennsylvania Medical Assistance (Medicaid) eligibility back. During this 6-month grace period, <i>you</i> are responsible for paying the 20%</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none">• Wet Macular Degeneration Agents <p>The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: www.geisinger.org/health-plan/plans/geisinger-gold-medicare/a-geisinger-gold-member</p> <p>We also cover some vaccines under our Part B and Part D prescription drug benefit.</p> <p>Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.</p>	<p>coinsurance to the provider for the portion of the cost sharing that Pennsylvania Medical Assistance (Medicaid) would have otherwise paid on your behalf.</p>
 Obesity screening and therapy to promote sustained weight loss	
<p>If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.</p> <p>Opioid treatment program services</p> <p>Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:</p> <ul style="list-style-type: none">• U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.• Dispensing and administration of MAT medications (if applicable)• Substance use counseling• Individual and group therapy• Toxicology testing• Intake activities• Periodic assessments <p><i>Prior Authorization is required. Your provider must contact our Plan prior to providing services by contacting the mental</i></p>	<p>There is no coinsurance, copayment, or deductible for in-network Medicare-covered preventive obesity screening and therapy.</p> <p>0% Coinsurance for in-network Medicare-covered Opioid Treatment Services</p> <p>Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Medicare-covered services you receive.</p> <p>If at any time during the benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you will be given a 6-month grace period to get your Pennsylvania Medical Assistance (Medicaid) eligibility back.</p>

Services that are covered for you	What you must pay when you get these services
<p><i>health/substance abuse phone number located on the back of your membership card.</i></p>	<p>During this 6-month grace period, <i>you</i> are responsible for paying the 20% coinsurance to the provider for the portion of the cost sharing that Pennsylvania Medical Assistance (Medicaid) would have otherwise paid on your behalf.</p>
<p>Outpatient diagnostic tests and therapeutic services and supplies</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none">• X-rays• Diagnostic radiology services, including Magnetic Resonance Imaging (MRI), Computed Axial Tomography (CT Scan) and Positron Emission Tomography (PET Scan), Magnetic Resonance Angiography (MRA), Nuclear Cardiology Studies, Virtual Colonoscopy.• Radiation (radium and isotope) therapy including technician materials and supplies• Surgical supplies, such as dressings• Splints, casts and other devices used to reduce fractures and dislocations• Laboratory tests• Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need, you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used• Other outpatient diagnostic tests <p><i>Prior Authorization is required for some services. Your provider must contact our Plan prior to providing services.</i></p>	<p>0% Coinsurance for in-network Medicare-covered outpatient diagnostic tests, therapeutic services, and supplies.</p> <p>Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Medicare-covered services you receive.</p> <p>If at any time during the benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you will be given a 6-month grace period to get your Pennsylvania Medical Assistance (Medicaid) eligibility back. During this 6-month grace period, <i>you</i> are responsible for paying the 20% coinsurance to the provider for the portion of the cost sharing that Pennsylvania Medical Assistance</p>

Services that are covered for you	What you must pay when you get these services
	(Medicaid) would have otherwise paid on your behalf.
<p>Outpatient hospital observation</p> <p>Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged.</p> <p>For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.</p> <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p> <p><i>Prior Authorization is required. Your provider must contact our Plan prior to providing services.</i></p>	<p>0% Coinsurance for in-network Medicare-covered observation services.</p> <p>Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Medicare-covered services you receive.</p> <p>If at any time during the benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you will be given a 6-month grace period to get your Pennsylvania Medical Assistance (Medicaid) eligibility back. During this 6-month grace period, <i>you</i> are responsible for paying the 20% coinsurance to the provider for the portion of the cost sharing that Pennsylvania Medical Assistance (Medicaid) would have otherwise paid on your behalf.</p>
<p>Outpatient hospital services</p> <p>We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>Covered services include, but are not limited to:</p>	<p>Outpatient copayments and/or coinsurance apply for covered services you receive as an outpatient.</p> <p>Please see each individual</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself <p><i>Prior Authorization is required. Your provider must contact our Plan prior to providing services.</i></p> <p><i>Medicare Part B prescription drugs require prior authorization and/or step therapy. Your provider must contact our plan.</i></p> <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	<p>outpatient benefit listed in this benefit chart for more information about covered outpatient services and the cost sharing amounts that apply to each service or item.</p> <p>Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Medicare-covered services you receive.</p> <p>If at any time during the benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you will be given a 6-month grace period to get your Pennsylvania Medical Assistance (Medicaid) eligibility back. During this 6-month grace period, <i>you</i> are responsible for paying the 20% coinsurance to the provider for the portion of the cost sharing that Pennsylvania Medical Assistance (Medicaid) would have otherwise paid on your behalf.</p>
<p>Outpatient mental health care</p> <p>Covered services include:</p> <p>Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p>	<p>0% Coinsurance for each in-network Medicare-covered mental health care individual session.</p>

Services that are covered for you	What you must pay when you get these services
<p><i>Prior Authorization is required. Your provider must contact our Plan prior to providing services by contacting the mental health/substance abuse phone number located on the back of your membership card.</i></p>	<p>0% Coinsurance for each in-network Medicare-covered mental health care group session.</p> <p>Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Medicare-covered services you receive.</p> <p>If at any time during the benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you will be given a 6-month grace period to get your Pennsylvania Medical Assistance (Medicaid) eligibility back. During this 6-month grace, <i>you</i> are responsible for paying the 20% coinsurance to the provider for the portion of the cost sharing that Pennsylvania Medical Assistance (Medicaid) would have otherwise paid on your behalf.</p>
<p>Outpatient rehabilitation services</p> <p>Covered services include: physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p>	<p>0% Coinsurance for in-network Medicare-covered outpatient rehabilitation services.</p> <p>Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Medicare-covered</p>

Services that are covered for you	What you must pay when you get these services
<p><i>Prior Authorization is required. Your provider must contact our Plan prior to providing services.</i></p>	<p>services you receive.</p> <p>If at any time during the benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you will be given a 6-month grace period to get your Pennsylvania Medical Assistance (Medicaid) eligibility back. During this 6-month grace, <i>you</i> are responsible for paying the 20% coinsurance to the provider for the portion of the cost sharing that Pennsylvania Medical Assistance (Medicaid) would have otherwise paid on your behalf.</p>
<p>Outpatient substance abuse services</p> <p>Medicare-covered outpatient substance abuse services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified substance abuse care professional as allowed under applicable state laws.</p> <p><i>Prior Authorization is required. Your provider must contact our Plan prior to providing services by contacting the mental health/substance abuse phone number located on the back of your membership card.</i></p>	<p>0% Coinsurance for in-network Medicare-covered outpatient substance abuse services.</p> <p>Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Medicare-covered services you receive.</p> <p>If at any time during the benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you will be given a 6-month grace period to get your Pennsylvania Medical Assistance (Medicaid) eligibility back.</p>

Services that are covered for you	What you must pay when you get these services
	<p>During this 6-month grace, <i>you</i> are responsible for paying the 20% coinsurance to the provider for the portion of the cost sharing that Pennsylvania Medical Assistance (Medicaid) would have otherwise paid on your behalf.</p>
<p>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</p> <p>Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”</p> <p><i>Prior Authorization is required. Your provider must contact our Plan prior to providing services.</i></p>	<p>0% Coinsurance for in-network Medicare-covered outpatient surgical services furnished in a physician’s office, certified ambulatory surgical center, hospital outpatient department, or any other location.</p> <p>Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Medicare-covered services you receive.</p> <p>If at any time during the benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you will be given a 6-month grace period to get your Pennsylvania Medical Assistance (Medicaid) eligibility back. During this 6-month grace, <i>you</i> are responsible for paying the 20% coinsurance to the provider for the portion of the cost sharing that Pennsylvania Medical</p>

Services that are covered for you	What you must pay when you get these services
	Assistance (Medicaid) would have otherwise paid on your behalf.
<p>Over-the-counter Medications/Supplies</p> <p>Geisinger Gold Secure Rx (HMO D-SNP) will cover certain over the counter (OTC) medications, vitamins and medical supplies, up to the monthly benefit limit.</p> <p>Geisinger Gold Secure Rx (HMO D-SNP) members receive a debit card in the mail, which can be used like a regular credit or debit card to purchase approved over-the-counter items at participating locations. A list of eligible OTC items and participating locations will be sent with your OTC debit card. These lists may be updated periodically.</p> <p>At the beginning of each calendar month, Geisinger Gold will apply the monthly benefit limit for you to use on approved OTC items during the month. Any unused balance on the card at the end of the month will not carry over to the following month.</p> <p>Members will swipe their OTC debit card at the check-out counter to pay for their eligible purchases, up to the monthly benefit limit.</p> <p>Please call Member Services at (800) 988-4861 (TTY users call PA Relay: 711).</p> <p>For OTC card services, including checking your balance and finding a participating retailer call 1-888-682-2400, or go to mybenefitscenter.com.</p> <p>For OTC card mail order services, call 833-569-2171 Monday - Friday 8 am -7 pm or go to https://athome.medline.com.geisinger</p>	<p>\$130 per month over-the-counter benefit allowance for covered over-the-counter medications and supplies.</p>
<p>Partial hospitalization services</p> <p>“Partial hospitalization” is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor’s or therapist’s office and</p>	<p>0% Coinsurance for in-network Medicare-covered partial hospitalization services.</p>

Services that are covered for you	What you must pay when you get these services
<p>is an alternative to inpatient hospitalization.</p> <p><i>Prior Authorization is required. Your provider must contact our Plan prior to providing services by contacting the mental health/substance abuse phone number located on the back of your membership card.</i></p>	<p>Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Medicare-covered services you receive.</p> <p>If at any time during the benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you will be given a 6-month grace period to get your Pennsylvania Medical Assistance (Medicaid) eligibility back. During this 6-month grace, <i>you</i> are responsible for paying the 20% coinsurance to the provider for the portion of the cost sharing that Pennsylvania Medical Assistance (Medicaid) would have otherwise paid on your behalf.</p>
<p>Personal emergency response system (PERS)</p> <p>The Personal Emergency Response System (PERS) is used to notify the appropriate personnel of primarily health-related emergencies (e.g., falls). In the event of an emergency the PERS device is activated when the member presses their personal help button. Benefit provides coverage for an in-home personal emergency response system up to the benefit limit each calendar year.</p>	<p>\$700 annual allowance for a one-time PERS activation fee, PERS device and service fees.</p>
<p>Physician/Practitioner services, including doctor’s office visits</p> <p>Covered services include:</p> <ul style="list-style-type: none">• Medically-necessary medical care or surgery services furnished in a physician’s office, certified ambulatory surgical center, hospital outpatient department, or any	<p>There is no coinsurance, copayment, or deductible for the in-network Medicare-covered Primary care visits.</p>

Services that are covered for you	What you must pay when you get these services
<p>other location</p> <ul style="list-style-type: none">• Consultation, diagnosis, and treatment by a specialist• Basic hearing and balance exams performed by your PCP, if your doctor orders it to see if you need medical treatment• You have the option of getting some professional services through an in-person visit or by telehealth. If you choose to get one of the professional services by telehealth, you must use a network provider who offers the service by telehealth.<ul style="list-style-type: none">○ The professional services available through telehealth, include: PCP Telehealth Services, Group Telehealth Mental Health Services, Group Telehealth Psychiatry Services, Group Telehealth Substance Abuse Services, Medical Urgent Care Telehealth Services, Individual Telehealth Mental Health Services, Individual Telehealth Psychiatry Services, Individual Telehealth Substance Abuse Services, Mental Health/Substance Abuse Urgent Care Telehealth Services, and Physician Specialist Telehealth Services⊕ For additional information on telehealth services, please go to this link: www.geisinger.org/health-plan/find/telemedicineandteladoc or call Member Services• Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare.• Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location• Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location	<p>0% Coinsurance for in-network Medicare-covered physician specialist visits and medical procedures.</p> <p>0% Coinsurance for in-network Medicare-covered outpatient surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location.</p> <p>0% Coinsurance for in-network Medicare-covered Telehealth Services as follows:</p> <p>0% Coinsurance for PCP Telehealth Services.</p> <p>0% Coinsurance for Group Telehealth Mental Health Services, Group Telehealth Psychiatry Services, Group Telehealth Substance Abuse Services, Medical Urgent Care Telehealth Services</p> <p>0% Coinsurance for Individual Telehealth Mental Health Services, Individual Telehealth Psychiatry Services, Individual Telehealth Substance Abuse Services, Mental Health/Substance</p>

Services that are covered for you	What you must pay when you get these services
	<p>benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you will be given a 6-month grace period to get your Pennsylvania Medical Assistance (Medicaid) eligibility back. During this 6-month grace, <i>you</i> are responsible for paying the 20% coinsurance to the provider for the portion of the cost sharing that Pennsylvania Medical Assistance (Medicaid) would have otherwise paid on your behalf.</p>
<p>Podiatry services Covered services include: Medicare-covered Podiatry Services:</p> <ul style="list-style-type: none">• Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs)• Routine foot care for members with certain medical conditions affecting the lower limbs• You must have a visit with your primary care physician or other ordering physician within six months of your podiatry appointment. Have this date handy when checking in for your appointment.• If you have an underlying condition, like diabetes, you must be seeing your ordering physician for it as it relates to your routine foot care. Your physician must document the underlying condition and include the information in the order (even though it's part of your medical record). This needs to occur every six months to qualify for coverage. <p>Supplemental Nail Trim Benefit:</p>	<p>0% Coinsurance for in-network Medicare-covered podiatry services.</p> <p>Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Medicare-covered services you receive.</p> <p>If at any time during the benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you will be given a 6-month grace period to get your Pennsylvania Medical Assistance (Medicaid) eligibility back. During this 6-month grace,</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none">In addition to your Medicare covered podiatry services, Geisinger Secure Rx (HMO D-SNP) provides a supplemental benefit that covers routine trimming of nail length up for four (4) times per calendar year at no costs.	<p><i>you</i> are responsible for paying the 20% coinsurance to the provider for the portion of the cost sharing that Pennsylvania Medical Assistance (Medicaid) would have otherwise paid on your behalf.</p> <p>\$0 Copayment for Supplemental in-network routine trimming of nails, up to four (4) visits per calendar year.</p>
<p> Prostate cancer screening exams</p> <p>For men age 50 and older, covered services include the following – each calendar year:</p> <ul style="list-style-type: none">Digital rectal examProstate Specific Antigen (PSA) test	<p>There is no coinsurance, copayment, or deductible for an annual in-network Medicare-covered preventive PSA test.</p>
<p>Prosthetic devices and related supplies</p> <p>Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail.</p> <p><i>Prior Authorization is required. Your provider must contact our Plan prior to providing services.</i></p>	<p>0% Coinsurance for in-network Medicare-covered prosthetic devices and related supplies.</p> <p>Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Medicare-covered services you receive.</p> <p>If at any time during the benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you will be given a 6-month grace period to get your Pennsylvania Medical Assistance</p>

Services that are covered for you	What you must pay when you get these services
	<p>(Medicaid) eligibility back. During this 6-month grace, <i>you</i> are responsible for paying the 20% coinsurance to the provider for the portion of the cost sharing that Pennsylvania Medical Assistance (Medicaid) would have otherwise paid on your behalf.</p>
<p>Pulmonary rehabilitation services</p> <p>Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.</p> <p><i>Prior Authorization is required. Your provider must contact our Plan prior to providing services.</i></p>	<p>0% Coinsurance for in-network Medicare-covered pulmonary rehabilitation services.</p> <p>Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Medicare-covered services you receive.</p> <p>If at any time during the benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you will be given a 6-month grace period to get your Pennsylvania Medical Assistance (Medicaid) eligibility back. During this 6-month grace, <i>you</i> are responsible for paying the 20% coinsurance to the provider for the portion of the cost sharing that Pennsylvania Medical Assistance (Medicaid) would have otherwise paid on your behalf.</p>

Services that are covered for you	What you must pay when you get these services
<p> Screening and counseling to reduce alcohol misuse</p> <p>We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent.</p> <p>If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.</p>	<p>There is no coinsurance, copayment, or deductible for the in-network Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit obtained from a primary care provider.</p>
<p> Screening for lung cancer with low dose computed tomography (LDCT)</p> <p>For qualified individuals, a LDCT is covered once each calendar year.</p> <p>Eligible members are: people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.</p> <p><i>For LDCT lung cancer screenings after the initial LDCT screening:</i> the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.</p>	<p>There is no coinsurance, copayment, or deductible for the in-network Medicare covered counseling and shared decision-making visit or for the LDCT.</p>
<p> Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</p> <p>We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once</p>	<p>There is no coinsurance, copayment, or deductible for the in-network Medicare-covered screening for STIs and counseling for STIs</p>

Services that are covered for you	What you must pay when you get these services
<p>each calendar year or at certain times during pregnancy.</p> <p>We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor’s office.</p>	<p>preventive benefit obtained from a primary care provider.</p>
<p>Services to treat kidney disease</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) <p>Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, “Medicare Part B prescription drugs.”</p>	<p>There is no coinsurance, copayment, or deductible for the in-network Medicare-covered kidney disease education services.</p> <p>0% Coinsurance for Medicare-covered kidney dialysis and other ESRD care and treatment services.</p> <p>Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Medicare-covered services you receive.</p> <p>If at any time during the benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you will be given a 6-month grace period to get your Pennsylvania Medical Assistance (Medicaid) eligibility back. During this 6-month grace, <i>you</i> are responsible for paying the 20% coinsurance to the provider for the</p>

Services that are covered for you	What you must pay when you get these services
	<p>portion of the cost sharing that Pennsylvania Medical Assistance (Medicaid) would have otherwise paid on your behalf.</p>
<p>Skilled nursing facility (SNF) care (For a definition of “skilled nursing facility care,” see Chapter 12 of this document. Skilled nursing facilities are sometimes called “SNFs.”) Up to 100 days are covered per benefit period. No prior hospital stay is required.</p> <p><i>Prior Authorization is required. Your provider must contact our Plan prior to providing services.</i></p> <p>Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need – you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. Storage and administration fees and all other components of blood are covered beginning with the first pint used • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services <p>Generally, you will get your SNF care from network facilities.</p>	<p><i>These are 2022 cost sharing amounts and may change for 2023:</i></p> <p>In 2022, you pay:</p> <ul style="list-style-type: none"> • \$1,556 deductible for each benefit period • \$0 for the first 60 days for each benefit period • \$389 per day for days 61-90 for each benefit period • \$778 per lifetime reserve day after 91 days of each benefit period (up to a maximum of 60 days over your lifetime) <p>A SNF benefit period begins the day you're admitted as an inpatient in a hospital or SNF. The benefit period ends when you haven't gotten any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins.</p>

Services that are covered for you	What you must pay when you get these services
<p>However, under certain conditions listed below, you may be able to get your care from a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.</p> <ul style="list-style-type: none">• A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care)• A SNF where your spouse is living at the time you leave the hospital	<p>Up to 100 days are covered per Medicare-covered benefit period. No prior hospital stay is required.</p> <p>A SNF benefit period begins the day you go into a skilled nursing facility. The benefit period ends when you haven't received any inpatient skilled care in a SNF or a hospital for 60 days in a row.</p> <p>Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Medicare-covered services you receive.</p> <p>If at any time during the benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you will be given a 6-month grace period to get your Pennsylvania Medical Assistance (Medicaid) eligibility back. During this 6-month grace, <i>you</i> are responsible for paying the provider for the portion of the cost sharing that Pennsylvania Medical Assistance (Medicaid) would have otherwise paid on your behalf.</p>
<p> Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</p>	

Services that are covered for you	What you must pay when you get these services
<p><u>If you use tobacco, but do not have signs or symptoms of tobacco-related disease:</u> We cover two counseling quit attempts each calendar year as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.</p> <p><u>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</u> We cover cessation counseling services. We cover two counseling quit attempts each calendar year, however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits.</p> <p>Geisinger Gold Secure Rx (HMO D-SNP) also has some coverage of Nicotine replacement therapy under your OTC benefit which includes nicotine gum, nicotine lozenges and nicotine patches.</p>	<p>There is no coinsurance, copayment, or deductible for the in-network Medicare-covered smoking and tobacco use cessation preventive benefits.</p>
<p>Special Supplemental Benefits for the Chronically III</p> <p>Members who meet CMS-defined SSBCI eligibility criteria and engage with plan-sponsored care management, enhanced disease management, or similar wellness programs <i>may</i> qualify for the following supplemental benefits:</p> <ul style="list-style-type: none">• fresh produce box• in home support• indoor air quality equipment and services• limited meals• structural home modifications• transitional/temporary supports <p>Plan representatives and Plan’s care staff will verify member eligibility and assess each individual’s disease state, treatment plan, and relevant social determinants to validate any supplemental benefit(s) provided will have reasonable impact toward maintaining or improving a member’s unique health status.</p> <p><i>As part of this SSBCI benefit, members who meet the eligibility criteria must receive pre-approval for any qualified benefit(s) from Plan’s care staff, and the pre-approved benefit(s) will be subject to the total annual benefit maximum.</i></p> <p><i>Individual approvals must be obtained for <u>each</u> SSBCI service or item covered under this benefit. Approvals expire at the end of each benefit year and/or approved services must be</i></p>	<p>All supplemental benefits provided as part of this SSBCI package will be subject to a total annual benefit maximum of \$3,000.</p>

Services that are covered for you	What you must pay when you get these services
<p><i>obtained before the approval expires. If the approved service is not obtained before the approval expires, the member must contact the plan and request a new approval</i></p> <p>See Important Benefit Information for Enrollees with Chronic Conditions in Section 2.1 of this Chapter for additional details.</p> <p>As a member of Geisinger Gold Secure Rx (HMO D-SNP), you are responsible for understanding that the benefit limit may not be exceeded.</p>	
<p>Supervised Exercise Therapy (SET)</p> <p>SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment.</p> <p>Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.</p> <p>The SET program must:</p> <ul style="list-style-type: none">• Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication• Be conducted in a hospital outpatient setting or a physician's office• Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD• Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques <p>SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.</p> <p><i>Prior Authorization is required. Your provider must contact our Plan prior to providing services.</i></p>	<p>0% Coinsurance for in-network Medicare-covered supervised exercise therapy services.</p> <p>Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Medicare-covered items and services you receive.</p> <p>If at any time during the benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you will be given a 6-month grace period to get your Pennsylvania Medical Assistance (Medicaid) eligibility back. During this 6-month grace, <i>you</i> are responsible for paying the 20% coinsurance to the provider for the portion of the cost sharing that Pennsylvania Medical Assistance (Medicaid) would have otherwise paid on your behalf.</p>

Services that are covered for you	What you must pay when you get these services
<p>Transportation Services</p> <p>Routine health-related non-emergency Medical transportation services include round-trip by taxi, bus, subway, van, uber or similar transportation services. Transportation is by ground only and must be to plan approved locations, such as doctor’s appointments, in order to obtain medically necessary care and services under the plans benefits. Drivers do not have medical training. In case of an emergency, call 911.</p> <ul style="list-style-type: none">• This benefit is not intended for Medical emergencies• Eligible Medicaid members may have Medicaid transportation benefits in addition to those provided by their Medicare Advantage Health Plan. <p>You may submit a claim form to receive reimbursement. The form is available on our website at www.GeisingerGold.com or you can contact Member Services to have a form mailed to you.</p>	<p>\$500 annual allowance for transportation services.</p>
<p>Urgently needed services</p> <p>Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but, given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. Examples of urgently needed services that the plan must cover out of network are 1) you need immediate care during the weekend, or 2) you are temporarily outside the service area of the plan. Services must be immediately needed and medically necessary. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider, then your plan will cover the urgently needed services from a provider out-of-network.</p> <p>(See Worldwide Emergency and Worldwide Urgent coverage section of this Benefit Chart for the worldwide urgent care benefit)</p> <p>Please contact Member Services for more details.</p>	<p>0% Coinsurance for Medicare-covered urgently needed care visits.</p> <p>If you are admitted to the hospital within 3 days for the same condition, you pay \$0 for the urgent care visit.</p> <p>Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Medicare-covered items and services you receive.</p> <p>If at any time during the benefit year you lose your Pennsylvania Medical Assistance (Medicaid) eligibility, you are responsible for paying the provider the 20% coinsurance that Pennsylvania Medical</p>

Services that are covered for you	What you must pay when you get these services
	Assistance (Medicaid) would have otherwise paid on your behalf.
<p>Vision care</p> <p> Preventive vision care</p> <ul style="list-style-type: none"> For people who are at high risk of glaucoma, we will cover one glaucoma screening each calendar year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older. <p>Other covered vision care services include:</p> <ul style="list-style-type: none"> Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts For people with diabetes, screening for diabetic retinopathy is covered once per each calendar year One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Routine eye exams (including a refraction) are covered by Geisinger Gold and are limited to one exam per calendar year. *Geisinger Gold will pay towards the purchase of routine (non-Medicare-covered) eyeglasses (lenses and frames), contact lenses, eyeglass frames and eyeglass lenses each calendar year. Items such as warranties, cleaning kits and dispensing fees are not covered. Eyewear may be purchased in-network or out-of-network. <p>*The Non-Medicare-covered eyewear listed in this section does not count toward the plan out-of-pocket maximum.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered preventive glaucoma screening for people who are at high risk. If the preventive glaucoma screening is given with an eye exam, the eye exam copay will apply for the visit.</p> <p>0% Coinsurance for in-network Medicare-covered eye exams to diagnose and treat diseases and conditions of the eye.</p> <p>\$0 Copayment for in-network Medicare-covered Diabetic Eye Exam.</p> <p>\$0 Copayment for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery.</p> <p>There is no coinsurance, copayment, or deductible for one in-network routine eye exam each year.</p> <p>If at any time during the benefit year you lose your Pennsylvania Medical</p>

Services that are covered for you	What you must pay when you get these services
	<p>Assistance (Medicaid) eligibility, you will be given a 6-month grace period to get your Pennsylvania Medical Assistance (Medicaid) eligibility back. During this 6-month grace, <i>you</i> are responsible for paying the 20% coinsurance to the provider for the portion of the cost sharing that Pennsylvania Medical Assistance (Medicaid) would have otherwise paid on your behalf.</p> <p>*\$425 annual allowance towards the purchase of routine (non-Medicare-covered) eyeglasses (lenses and/or frames) or contact lenses.</p> <p>Your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for Medicare-covered items and services you receive.</p>
<p> “Welcome to Medicare” preventive visit</p> <p>The plan covers the one-time “Welcome to Medicare” preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.</p> <p>The plan will also cover the Medicare-covered one-time screening EKG as a result of your “Welcome to Medicare” preventive visit. You must get an order from your provider for the one-time screening EKG.</p> <p>Important: We cover the “Welcome to Medicare” preventive visit only within the first 12 months you have Medicare Part B.</p>	<p>There is no coinsurance, copayment, or deductible for the in-network Medicare-covered “Welcome to Medicare” preventive visit.</p>

Services that are covered for you	What you must pay when you get these services
<p>When you make your appointment, let your doctor’s office know you would like to schedule your “Welcome to Medicare” preventive visit.</p>	
<p>Worldwide emergency/urgent coverage</p> <p>Worldwide emergency/urgent coverage services are covered up to a combined benefit limit of \$100,000 per year.</p> <p>If a medical emergency or an urgent need for medical services occurs while you are traveling outside the U.S., your Geisinger Gold Worldwide Emergency/Urgent Coverage benefit will cover Emergency or Urgently Needed Services and Emergency Ambulance Transportation you receive outside of the United States and its territories. Emergency Care and Urgently Needed Services coverage is limited to care that would be classified as emergency or urgently needed services had you received them inside the United States.</p> <p>We cover emergency ambulance transport to the nearest appropriate facility that can provide emergency care when the member’s emergency medical condition is such that any other means of transportation could seriously endanger the member’s health. Worldwide Emergency Coverage Worldwide Emergency Transportation, and Worldwide Urgent Coverage is a combined benefit limit of \$100,000 per year. Medical Evacuation from a foreign country back to the United States is covered by Geisinger Gold. Non-emergency ambulance services are not covered outside of the US and its territories.</p> <p>If an urgent need for medical services occurs while you are traveling outside the United States, your Geisinger Gold Worldwide Emergency/Urgent Coverage benefit will cover urgently needed services you receive outside of the United States and its territories. Coverage is limited to services that would be classified as urgently needed services had you received them inside the United States. Our plan does not cover non-emergency/non-urgent services if you receive the care outside of the United States.</p> <p>Because the coverage provided by the Geisinger Gold Worldwide Emergency/Urgent Coverage benefit is limited to</p>	<p>\$0 Copayment for covered Worldwide emergency ground ambulance transport outside the United States.</p> <p>\$0 Copayment for covered Worldwide emergency air ambulance transport outside the United States.</p> <p>\$0 Copayment for worldwide emergency services received outside of the United States.</p> <p>\$0 Copayment for Worldwide urgent care outside of the United States.</p>

Services that are covered for you	What you must pay when you get these services
<p>emergency or urgently needed services outside the United States, you may want to consider buying a travel insurance policy to get more coverage. A travel agent can give you more information about buying travel insurance. Not all travel insurance includes health care coverage, so it is important to understand what the travel insurance policy covers and any restrictions before purchasing.</p> <p>Geisinger Gold does not cover non-emergency/non-urgent services you receive outside of the United States and its territories.</p> <p>Please contact Member Services for more details.</p>	

SECTION 3 What services are not covered by the plan?

Section 3.1	Services <i>not</i> covered by the plan (exclusions)
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This section tells you what services are “excluded” by the Medicare.

The chart below describes some services and items that aren’t covered by the plan under any conditions or are covered by only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them. The only exception is if the service is appealed and decided: upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 6.3 in this document.)

All exclusions or limitations on services are described in the Benefits Chart or in the chart below.

Chapter 4 Medical Benefits Chart (what is covered)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture		<p style="text-align: center;">✓</p> Available for people with chronic low back pain under certain circumstances. Please see acupuncture services in the Benefit Chart.
Cosmetic surgery or procedures		<p style="text-align: center;">✓</p> <ul style="list-style-type: none"> • Covered in cases of an accidental injury or for improvement of the functioning of a malformed body part. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.		<p style="text-align: center;">✓</p> Please see Special Supplemental Benefits for the Chronically ill in the Benefit Chart.
Drugs, items, supplies or services that are self-prescribed, self-provided (rendered by one's self), or are prescribed and/or provided to you by any person related to you by blood or marriage are not covered.	✓	

Chapter 4 Medical Benefits Chart (what is covered)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
<p>Experimental or investigational medical and surgical procedures, equipment and medications.</p> <p>Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.</p>		<p style="text-align: center;">✓</p> <p>May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan.</p> <p>(See Chapter 3, Section 5 for more information on clinical research studies.)</p>
Fees charged for care by your immediate relatives or members of your household.	✓	
Full-time nursing care in your home.	✓	
Home-delivered meals		<p style="text-align: center;">✓</p> <p>Please see Special Supplemental Benefits for the Chronically ill in the Benefit Chart.</p>
Homemaker services including basic household assistance, such as light housekeeping or light meal preparation.		<p style="text-align: center;">✓</p> <p>Please see Special Supplemental Benefits for the Chronically ill in the Benefit Chart.</p>
Naturopath services (uses natural or alternative treatments).	✓	
Non-routine dental care		<p style="text-align: center;">✓</p> <p>Dental care required to treat illness or injury may be covered as inpatient or outpatient care.</p>
Orthopedic shoes or supportive devices for the feet		<p style="text-align: center;">✓</p> <p>Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.</p>
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	✓	

Chapter 4 Medical Benefits Chart (what is covered)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Private room in a hospital.		<p style="text-align: center;">✓</p> Covered only when medically necessary.
Reversal of sterilization procedures and/or non-prescription contraceptive supplies.	✓	
Routine chiropractic care		<p style="text-align: center;">✓</p> Manual manipulation of the spine to correct a subluxation is covered.
Routine dental care, such as cleanings, fillings or dentures.		<p style="text-align: center;">✓</p> Please see Dental Services in the Benefit Chart.
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids.		<p style="text-align: center;">✓</p> Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery. Please see Vision Care in the Benefit Chart.
Routine foot care		<p style="text-align: center;">✓</p> Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes). Please see Podiatry Services in the Benefit Chart.
Routine hearing exams, hearing aids, or exams to fit hearing aids.		<p style="text-align: center;">✓</p> Please see Hearing Services in the Benefit Chart.
Services considered not reasonable and necessary, according to Original Medicare standards	✓	

CHAPTER 5:

*Using the plan's coverage for Part D
prescription drugs*



How can you get information about your drug costs?

Because you are eligible for Pennsylvania Medical Assistance (Medicaid), you qualify for and are getting “Extra Help” from Medicare to pay for your prescription drug plan costs. Because you are in the “Extra Help” program, **some information in this *Evidence of Coverage* about the 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 known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Member Services and ask for the “LIS Rider.”

SECTION 1 Introduction

This chapter **explains rules for using your coverage for Part D drugs.** Please see Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Pennsylvania Medical Assistance (Medicaid) benefits. For more information about your Medical Assistance (Medicaid) benefits, please contact the Pennsylvania Medical Assistance (Medicaid) office at 1-800-642-7462, your Community HealthChoices Plan or your Local County Assistance Office. (Contact information is listed in Chapter 2, section 6 of this document.)

Section 1.1 Basic rules for the plan's Part D drug coverage
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The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription which must be valid under applicable state law.
- Your prescriber must not be on Medicare’s Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan’s mail-order service*).
- Your drug must be on the plan’s *List of Covered Drugs (Formulary)* (we call it the “Drug List” for short). (See Section 3, *Your drugs need to be on the plan’s “Drug List”*).
- Your drug must be used for a medically accepted indication. A “medically accepted indication” is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

SECTION 2 Fill your prescription at a network pharmacy or through the plan's mail-order service

Section 2.1 Use a network pharmacy
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In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are on the plan's Drug List.

Section 2.2 Network pharmacies
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How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Provider Directory*, visit our website (www.GeisingerGold.com) and/or call Pharmacy Member Services.

You may go to any of our network pharmacies.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another pharmacy in your area, you can get help from Pharmacy Member Services or use the *Provider Directory*. You can also find information on our website at www.GeisingerGold.com.

What if you need a specialized pharmacy?

Some prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy. Please refer to your *Provider Directory* to find a home infusion pharmacy provider in your area or you can get help from Pharmacy Member Services.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Pharmacy Member Services.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.

- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (**Note:** This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Provider Directory* or call Pharmacy Member Services.

Section 2.3 Using the plan's mail-order service

For certain kinds of drugs, you can use the plan's network mail-order service. Generally, the drugs provided through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition. The drugs that are *not* available through the plan's mail-order service are marked with "NM" in our Drug List.

Our plan's mail-order service allows you to order **up to a 100-day supply**.

To get information about filling your prescriptions by mail-order please call Pharmacy Member Services, or by calling Geisinger mail order pharmacy at 1-844-878-5562.

Usually, a mail-order pharmacy order will be delivered to you in no more than 10 days. However, sometimes your mail-order may be delayed. If this occurs, Geisinger Gold will coordinate with your retail pharmacist and mail order facility to see that you receive necessary medications. If your mail-order pharmacy order is delayed, please call Pharmacy Member Services.

New prescriptions the pharmacy receives directly from your doctor's office.

After the pharmacy receives a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. It is important that you respond each time you are contacted by the pharmacy, to let them know whether to ship, delay, or stop the new prescription.

Refills on mail-order prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.

If you choose not to use our auto-refill program but still want the mail-order pharmacy to send you your prescription, please contact your mail-order pharmacy 21 days before your current prescription will run out. This will ensure your order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, please contact us by calling Pharmacy Member Services, or by calling Geisinger mail order pharmacy at 1-844-878-5562.

If you receive a refill automatically by mail that you do not want, you may be eligible for a refund.

Section 2.4 How can you get a long-term supply of drugs?

The plan offers two ways to get a long-term supply (also called an “extended supply”) of “maintenance” drugs on our plan’s Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your *Provider Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Pharmacy Member Services for more information
2. You may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information.

Section 2.5 When can you use a pharmacy that is not in the plan's network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. **Please check first with Pharmacy Member Services** to see if there is a network pharmacy nearby. You will most likely be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- If you are unable to get a covered drug in a timely manner within our service area, because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.
- If you are trying to fill a covered prescription drug that is not regularly stocked at an eligible network retail or mail order pharmacy (these drugs include orphan drugs or other specialty pharmaceuticals).
- Getting your prescription drugs in a disaster or emergency. If the Governor, the U.S. Secretary of Health and Human Services, or the President of the United States declares a disaster or emergency in your local area, the usual rules for obtaining your prescription drugs may change for a short time. Contact Geisinger Gold if you had to leave your home without your drugs, or your drugs have been damaged or lost because of the emergency or disaster. The number to call is on the back of your

Geisinger Gold membership card. If you can't reasonably get to a network pharmacy, we can help you get drugs during an emergency or disaster at an out-of-network pharmacy at the in-network cost sharing rate.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost at the time you fill your prescription. You can ask us to reimburse you. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

Please note that Geisinger Gold is not allowed to reimburse members for Pennsylvania Medical Assistance (Medicaid) covered benefits. If you have questions, please contact Member Services.

SECTION 3 Your drugs need to be on the plan's "Drug List"

Section 3.1 The "Drug List" tells which Part D drugs are covered

The plan has a "*List of Covered Drugs (Formulary)*." In this *Evidence of Coverage*, we call it the "**Drug List**" for short.

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare.

The Drug List includes the drugs covered under Medicare Part D. In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Pennsylvania Medical Assistance (Medicaid) benefits. Please contact your Pennsylvania Medical Assistance (Medicaid) program to learn what Medical Assistance (Medicaid) drug coverage may be available to you. You may also contact your Community HealthChoices Plan. (Contact information is listed in Chapter 2, Section 6 of this document.)

We will generally cover a drug on the plan's Drug List as long as you follow the coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is *either*:

- Approved by the Food and Drug Administration for the diagnosis or condition for which it is being prescribed.
- *or* -- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

"The Drug List includes brand name drugs and generic drugs.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example,

drugs that are based on a protein) are called biological products. On the drug list, when we refer to “drugs,” this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug or biological product and usually cost less. There are generic drug substitutes or biosimilar alternatives available for many brand name drugs and some biological products.

Over-the-Counter Drugs

Our plan also covers certain over-the-counter drugs. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. For more information, please refer to the OTC Medications section in the Benefits Chart in Chapter 4 or call Pharmacy Member Services.

What is *not* on the Drug List?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on the Drug List. In some cases, you may be able to obtain a drug that is not on the drug list. For more information, please see Chapter 9.
- The Geisinger Gold Drug List does not include drugs that are not covered by your Geisinger Gold Secure Rx (HMO D-SNP) plan but may be covered under your Pennsylvania Medical Assistance (Medicaid) Benefit. For information about drugs which may be covered by your Pennsylvania Medical Assistance (Medicaid) benefits, please contact the Pennsylvania Medical Assistance (Medicaid) office at 1-800-642-7462, your Community HealthChoices Plan or your local County Assistance Office (Contact information is listed in Chapter 2, section 6 of this document.)

Section 3.2	How can you find out if a specific drug is on the Drug List?
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You have three ways to find out:

1. Check the most recent Drug List we sent you in the mail.
2. Visit the plan's website (www.GeisingerGold.com). The Drug List on the website is always the most current.
3. Call Pharmacy Member Services to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?
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For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. If a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option.

Please note that sometimes a drug may appear more than once in our drug list. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care provider, and different restrictions or cost sharing may apply to the different versions of the drug (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 What kinds of restrictions?

The sections below tell you more about the types of restrictions we use for certain drugs.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. Contact Pharmacy Member Services to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9).

Restricting brand name drugs when a generic version is available

Generally, a “generic” drug works the same as a brand name drug and usually costs less. **When a generic version of a brand name drug is available, our network pharmacies will provide you the generic version instead of the brand name drug.** However, if your provider has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug. (Your share of the cost may be greater for the brand name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called “**prior authorization.**” This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition and Drug A is less costly, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called “**step therapy.**”

Quantity limits

For certain drugs, we limit how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

Section 4.3	Hepatitis C Treatment at a Center of Excellence (COE)
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Members with Hepatitis C are encouraged to visit a Center of Excellence for treatment. A COE is a group of licensed physicians who share a hospital or medical center in order to provide high quality specialty healthcare for chronic conditions. Physicians located in the COE demonstrate best practices by using clinically proven health care management techniques as evidenced by their exceptional cure rates following treatment, high adherence rates for medication and excellent patient satisfaction scores. Geisinger Gold currently has four COE facilities that focus on treatment of Hepatitis C. Hepatitis C viral infection can be a chronic condition where scarring can damage the liver over time. Questions may be directed to the Pharmacy Customer Service Team at 800-988-4861.

SECTION 5

What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1	There are things you can do if your drug is not covered in the way you'd like it to be covered
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There are situations where there is a prescription drug you are taking, or one that you and your provider think you should be taking, that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug, as explained in Section 4.
- There are things you can do if your drug is not covered in the way that you'd like it to be covered.

- If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.

Section 5.2	What can you do if your drug is not on the Drug List or if the drug is restricted in some way?
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If your drug is not on the Drug List or is restricted, here are options:

- You may be able to get a temporary supply of the drug.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, the plan must provide a temporary supply of a drug that you are already taking. This temporary supply gives you time to talk with your provider about the change in coverage and decide what to do.

To be eligible for a temporary supply, the drug you have been taking **must no longer be on the plan's Drug List OR is now restricted in some way.**

- **If you are a new member**, we will cover a temporary supply of your drug during the first 90 days of your membership in the plan.
- **If you were in the plan last year**, we will cover a temporary supply of your drug during the first 90 days of the calendar year.
- This temporary supply will be for a maximum of 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 30-day supply of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For those members who have been in the plan for more than 90 days and reside in a long-term care facility and need a supply right away:**

We will cover one 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.

- For level of care changes, early refill restrictions will not be used to limit access to a Member's Part D benefit. Members changing from one treatment setting to another (e.g., hospital to LTC facility, or hospital to home), admitted or discharged from a long-term care facility or experiencing similar level of care changes may obtain a refill upon admission or discharge.

For questions about a temporary supply, call Pharmacy Member Services.

During the time when you are using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have two options:

1) You can change to another drug

Talk with your provider about whether there is a different drug covered by the plan that may work just as well for you. You can call Pharmacy Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

2) You can ask for an exception

You and your provider can ask the plan to make an exception and cover the drug in the way you would like it covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception. For example, you can ask the plan to cover a drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you and your provider want to ask for an exception, Chapter 9, Section 7.4 tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 The Drug List can change during the year
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Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan can make some changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List.**
- **Add or remove a restriction on coverage for a drug.**
- **Replace a brand name drug with a generic drug.**

We must follow Medicare requirements before we change the plan's Drug List.

Section 6.2 What happens if coverage changes for a drug you are taking?

Information on changes to drug coverage

When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List on a regularly scheduled basis. Below we point out the times that you would get direct notice if changes are made to a drug that you are taking.

Changes to your drug coverage that affect you during the current plan year

- **A new generic drug replaces a brand name drug on the Drug List (or we change the cost-sharing tier or add new restrictions to the brand name drug or both)**
 - We may immediately remove a brand name drug on our Drug List if we are replacing it with a newly approved generic version of the same drug. We may decide to keep the brand name drug on our Drug List or add new restrictions or both when the new generic is added.
 - We may not tell you in advance before we make that change—even if you are currently taking the brand name drug. If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s). This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.
 - You or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 9.
- **Unsafe drugs and other drugs on the Drug List that are withdrawn from the market**
 - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you are taking that drug, we will tell you right away.
 - Your prescriber will also know about this change, and can work with you to find another drug for your condition.
- **Other changes to drugs on the Drug List**
 - We may make other changes once the year has started that affect drugs you are taking. For example, we might add a generic drug that is not new to the market to replace a brand name drug on the Drug List or add new restrictions to the brand name drug or both. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
 - For these changes, we must give you at least 30 days' advance notice of the change or give you notice of the change and a 30 day refill of the drug you are taking at a network pharmacy.

- After you receive notice of the change, you should work with your prescriber to switch to a different drug that we cover or to satisfy any new restrictions on the drug you are taking.
- You or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 9.

Changes to the Drug List that do not affect you during this plan year

We may make certain changes to the Drug List that are not described above. In these cases, the change will not apply to you if you are taking the drug when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in the same plan.

In general, changes that will not affect you during the current plan year are:

- We put a new restriction on the use of your drug.
- We remove your drug from the Drug List.

If any of these changes happen for a drug you are taking (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restrictions to your use of the drug.

We will not tell you about these types of changes directly during the current plan year. You will need to check the Drug List for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to the drugs you are taking that will impact you during the next plan year.

SECTION 7 What types of drugs are *not* covered by the plan?

Section 7.1 Types of drugs we do not cover
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This section tells you what kinds of prescription drugs are “excluded.” This means Medicare does not pay for these drugs.

If you appeal and the requested drug is found not to be excluded under Part D, we will pay for or cover it. (For information about appealing a decision, go to Chapter 9.) If the drug is excluded, you must pay for it yourself.

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States or its territories.
- Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
- Coverage for "off-label use" is allowed only when the use is supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

In addition, by law, the following categories of drugs listed below are not covered by Medicare. However, some of these drugs may be covered for you under your Pennsylvania Medical Assistance (Medicaid) drug coverage as indicated below.

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

Your Pennsylvania Medical Assistance (Medicaid) benefit may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your Pennsylvania Medical Assistance (Medicaid) program to learn what Pennsylvania Medical Assistance (Medicaid) drug coverage may be available to you. You may also contact your Community HealthChoices Plan. (Contact information is listed in Chapter 2, Section 6 of this document.)

SECTION 8 Filling a prescription

Section 8.1 Provide your membership information

To fill your prescription, provide your plan membership information, which can be found on your membership card, at the network pharmacy you choose. The network pharmacy will automatically bill the plan for our share of the costs of your drug.

Section 8.2	What if you don't have your membership information with you?
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If you don't have your plan membership information with you when you fill your prescription, you or the pharmacy can call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up.** (You can then ask us to reimburse you. See Chapter 7, Section 2.1 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1	What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?
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If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your prescription drugs as long as the drugs meet all of our rules for coverage described in this Chapter.

Section 9.2	What if you're a resident in a long-term care (LTC) facility?
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Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy, or uses a pharmacy that supplies drugs for all of its residents. If you are a resident of a LTC facility, you may get your prescription drugs through the facility's pharmacy or the one it uses, as long as it is part of our network.

Check your *Provider Directory* to find out if your LTC facility's pharmacy or the one that it uses is part of our network. If it isn't, or if you need more information or assistance, please contact Pharmacy Member Services. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies.

What if you're a resident in a long-term care (LTC) facility and need a drug that is not on our Drug List or is restricted in some way?

Please refer to Section 5.2 about a temporary or emergency supply.

Section 9.3	What if you're in Medicare-certified hospice?
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Hospice and our plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea, laxative, pain medication or antianxiety drugs) that are not covered by your hospice because it is unrelated to your terminal

illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely
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We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug to treat the same condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking
- Unsafe amounts of opioid pain medications

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

Section 10.2 Drug Management Program (DMP) to help members safely use their opioid medications
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We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of

prescription opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain doctor(s)
- Limiting the amount of opioid or benzodiazepine medications we will cover for you

If we plan on limiting how you may get these medications or how much you can get, we will send you a letter in advance. The letter will explain the limitations we think should apply to you. You will have an opportunity to tell us which doctors or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our determination or with the limitation, you and your prescriber have the right to appeal. If you appeal, we will review your case and give you a decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 9 for information about how to ask for an appeal.

You will not be placed in our DMP if you have certain medical conditions, such as active cancer-related pain or sickle cell disease, you are receiving hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.3	Medication Therapy Management (MTM) program to help members manage their medications
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We have a program that can help our members with complex health needs. "Our" program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the program for us to help make sure that our members get the most benefit from the drugs they take.

Some members who take medications for different medical conditions and have high drug costs, or are in a DMP to help members use their opioids safely, may be able to get services through an MTM program. A pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will receive information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list up to date and with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you. If you have any questions about this program, please contact Pharmacy Member Services.

CHAPTER 6:

*What you pay for your Part D
prescription drugs*



How can you get information about your drug costs if you're receiving "Extra Help" with your Part D prescription drug costs?

Because you are eligible for Pennsylvania Medical Assistance (Medicaid), you qualify for and are getting "Extra Help" from Medicare to pay for your prescription drug plan costs. Because you are in the "Extra Help" program, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** If you are in the "Extra Help" program, **some information in this *Evidence of Coverage* about the 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 known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Member Services and ask for the "LIS Rider."

SECTION 1 Introduction

Section 1.1	Use this chapter together with other materials that explain your drug coverage
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This chapter focuses on what you pay for Part D prescription drugs. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs. Some drugs are excluded from Part D coverage by law. Some of the drugs excluded from Part D coverage are covered under Medicare Part A or Part B or under Pennsylvania Medical Assistance (Medicaid).

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5, Sections 1 through 4 explain these rules.:

Section 1.2	Types of out-of-pocket costs you may pay for covered drugs
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There are different types of out-of-pocket costs for Part D drugs. The amount that you pay for a drug is called "cost sharing," and there are three ways you may be asked to pay.

- The "**deductible**" is the amount you pay for drugs before our plan begins to pay its share.
- "**Copayment**" is a fixed amount you pay each time you fill a prescription.
- "**Coinsurance**" is a percentage of the total cost you pay each time you fill a prescription.

Section 1.3	How Medicare calculates your out-of-pocket costs
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Medicare has rules about what counts and what does *not* count toward your out-of-pocket costs. Here are the rules we must follow to keep track of your out-of-pocket costs.

These payments are included in your out-of-pocket costs

Your out-of-pocket costs include the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5):

- The amount you pay for drugs when you are in any of the following drug payment stages:
 - The Deductible Stage
 - The Initial Coverage Stage
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* if they are made on your behalf by **certain other individuals or organizations**. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare’s “Extra Help” Program are also included.
- Some payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of \$7,400 in out-of-pocket costs within the calendar year, you will move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments are not included in your out-of-pocket costs

Your out-of-pocket costs **do not include** any of these types of payments:

- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan’s requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Drugs covered by Pennsylvania Medical Assistance (Medicaid) only.

Chapter 6 What you pay for your Part D prescription drugs

- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your brand or generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Affairs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan by calling Member Services.

How can you keep track of your out-of-pocket total?

- **We will help you.** The Part D Explanation of Benefits (EOB) report you receive includes the current amount of your out-of-pocket costs. When this amount reaches \$7,400, this report will tell you that you have left the Initial Coverage Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 2 What you pay for a drug depends on which “drug payment stage” you are in when you get the drug

Section 2.1 What are the drug payment stages for Geisinger Gold Secure Rx (HMO D-SNP) members?
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There are four “drug payment stages” for your Medicare Part D prescription drug coverage under Geisinger Gold Secure Rx (HMO D-SNP). How much you pay depends on what stage you are in when you get a prescription filled or refilled. Details of each stage are in Sections 4 through 7 of this chapter. The stages are:

Stage 1: Yearly Deductible Stage

Stage 2: Initial Coverage Stage

Stage 3: Coverage Gap Stage

Stage 4: Catastrophic Coverage Stage

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly summary called the <i>Part D Explanation of Benefits</i> (the “Part D EOB”)

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your “**out-of-pocket**” cost.
- We keep track of your “**total drug costs.**” This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

If you have had one or more prescriptions filled through the plan during the previous month we will send you a *Part D Explanation of Benefits* (“Part D EOB”). The Part D EOB includes:

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called “year-to-date” information. It shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This information will display the total drug price, and information about increases in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This will include information about other available drugs with lower cost sharing for each prescription claim.

Section 3.2 Help us keep our information about your drug payments up to date
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To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card every time you get a prescription filled.** This helps us make sure we know about the prescriptions you are filling and what you are paying.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of

Chapter 6 What you pay for your Part D prescription drugs

your out-of-pocket costs, give us copies of your receipts Here are examples of when you should give us copies of your drug receipts:

- When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit
- When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program
- Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances

If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2. Please note **that Geisinger Gold is not allowed to reimburse members for Pennsylvania Medical Assistance (Medicaid) covered benefits.** If you have questions, please contact Pharmacy Member Services). Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:

- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive the Part D EOB, look it over to be sure the information is complete and correct. If you think something is missing or you have any questions, please call us at Pharmacy Member Services. Be sure to keep these reports.

SECTION 4 During the Deductible Stage, you pay the full cost of your drugs

Because most of our members get “Extra Help” with their prescription drug costs, the Deductible Stage does not apply to most members. If you receive “Extra Help,” this payment stage does not apply to you.

Look at the separate insert (the “LIS Rider”) for information about your deductible amount.

If you do not receive “Extra Help,” the Deductible Stage is the first payment stage for your drug coverage. This stage begins when you fill your first prescription in the year. When you are in this payment stage, **you must pay the full cost of your drugs** until you reach the plan's deductible amount, which is \$505 for 2023. **You must pay the full cost of your drugs** until you reach the plan's deductible amount. For all other drugs, you will not have to pay any deductible. The “**full cost**” is usually lower than the normal full price of the drug, since our plan has negotiated lower costs for most drugs at network pharmacies.

Once you have paid \$505 for your drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription
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During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A network retail pharmacy
- A pharmacy that is not in the plan’s network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 to find out when we will cover a prescription filled at an out-of-network pharmacy.
- The plan’s mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 and the plan’s *Pharmacy Directory*.

Section 5.2 A table that shows your costs for a one-month supply of a drug
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During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

As shown in the table below, the amount of the copayment or coinsurance depends on your level of “Extra Help”. Please note:

- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 for information about when we will cover a prescription filled at an out-of-network pharmacy.

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug during the Initial Coverage Stage:

	Standard Retail cost sharing (in-network) (up to a 30-day supply)	Long-term care (LTC) cost sharing (up to a 31-day supply)	Out-of-network cost sharing (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 30-day supply)
To find out your level of “Extra Help” please refer to your Low-Income Subsidy (LIS) Rider			
Extra Help Copayments – Low Income Subsidy Level 25%, 50%, 75% and 100%			
Generic Drugs	\$0.00 Copayment	\$0.00 Copayment	\$0.00 Copayment
Brand Name Drugs	\$0.00 Copayment	\$0.00 Copayment	\$0.00 Copayment
Standard Medicare Part D Benefit – Does Not Receive “Extra Help” *			
Generic Drugs	25% Coinsurance	25% Coinsurance	25% Coinsurance
Brand Name Drugs	25% Coinsurance	25% Coinsurance	25% Coinsurance

Section 5.3 If your doctor prescribes less than a full month’s supply, you may not have to pay the cost of the entire month’s supply

Typically, the amount you pay for a prescription drug covers a full month’s supply. There may be times when you or your doctor would like you to have less than a month’s supply of a drug (for example, when you are trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month’s supply of your drugs, if this will help you better plan refill dates for different prescriptions.

If you receive less than a full month’s supply of certain drugs, you will not have to pay for the full month’s supply.

- If you are responsible for coinsurance, you pay a *percentage* of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you are responsible for a copayment for the drug, you will only pay for the number of days of the drug that you receive instead of a whole month. We will calculate the amount you pay per day for your drug (the “daily cost-sharing rate”) and multiply it by the number of days of the drug you receive.

Section 5.4 A table that shows your costs for a *long-term* (up to a 100-day) supply of a drug

For some drugs, you can get a long-term supply (also called an “extended supply”). A long-term supply is up to a 100-day supply.

The table below shows what you pay when you get a long-term supply of a drug.

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug:

	Standard Retail cost sharing (in-network) (up to a 100-day supply)	Mail-order cost sharing (up to a 100-day supply)
To find out your level of “Extra Help” please refer to your Low-Income Subsidy (LIS) Rider		
Extra Help Copayments – Low Income Subsidy Level 25%, 50%, 75% and 100%		
Generic Drugs	\$0.00 Copayment	\$0.00 Copayment
Brand Name Drugs	\$0.00 Copayment	\$0.00 Copayment
Standard Medicare Part D Benefit – Does Not Receive “Extra Help” *		
Generic Drugs	25% Coinsurance	25% Coinsurance
Brand Name Drugs	25% Coinsurance	25% Coinsurance

*Please note that all Geisinger Gold Secure Rx (HMO D-SNP) members are eligible to receive “Extra Help” with their prescription drug costs. If you do not receive “Extra Help” please contact Member Services.

Section 5.5 You stay in the Initial Coverage Stage until your total drug costs for the year reach \$4,660

If you do not receive “Extra Help” to pay for your prescription drugs, you stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled reaches the \$4,660 limit for the Initial Coverage Stage.

You then move on to the Catastrophic Coverage Stage.

The Part D EOB that you receive will help you keep track of how much you, the plan, and any third parties have spent on your behalf during the year. Many people do not reach the \$4,660 limit in a year.

Chapter 6 What you pay for your Part D prescription drugs

If you receive “Extra Help” to pay for your prescription drugs, we will let you know if you reach this \$7,400 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

If you do not receive “Extra Help” to pay for your prescription drugs, we will let you know if you reach the \$4,660 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage

We will let you know if you reach this amount. If you do reach this amount and you do not receive “Extra Help”, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage or if you do receive “Extra Help”, you will leave the initial Coverage Stage and move onto the Catastrophic Coverage Stage. See Section 1.3 on how Medicare calculates your out-of-pocket costs.

SECTION 6 Costs in the Coverage Gap Stage

If you receive “Extra Help” from Medicare (LIS) for your prescription drug costs, you do not have a coverage gap for your Part D drugs and this section does not apply to you. Once you leave the Initial Coverage Stage, you move on to the Catastrophic Coverage Stage. See Section 7 for information about your coverage in the Catastrophic Coverage Stage.

If you do not receive “Extra Help” from Medicare (LIS) for your prescription drug costs, you stay in the Coverage Gap Stage until your out-of-pocket costs reach \$7,400.

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 25% of the negotiated price and a portion of the dispensing fee for brand name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and move you through the coverage gap.

You also receive some coverage for generic drugs. You pay no more than 25% of the cost for generic drugs and the plan pays the rest. Only the amount you pay counts and moves you through the coverage gap.

You continue paying these costs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. Once you reach this amount (\$7,400), you leave the Coverage Gap Stage and move to the Catastrophic Coverage Stage.

Medicare has rules about what counts and what does *not* count toward your out-of-pocket costs (Section 1.3).

SECTION 7 During the Catastrophic Coverage Stage, the plan pays all or most of the costs for your drugs

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the \$7,400 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

If you receive “Extra Help” Low Income Subsidy (LIS) from Medicare for your prescription drug costs:

During this stage, the plan will pay all of the costs for your drugs.

If you do not receive “Extra Help” Low Income Subsidy (LIS) from Medicare for your prescription drug costs:

- **Your share** of the cost for a covered drug will be either coinsurance or a copayment, whichever is the *larger* amount:
 - – *either* – Coinsurance of 5% of the cost of the drug
 - – *or* – \$4.15 for a generic drug or a drug that is treated like a generic and \$10.35 for all other drugs.

Look at the separate insert (the “LIS Rider”) for information about your costs during the Catastrophic Coverage Stage.

SECTION 8 Additional benefits information

Since you are enrolled in Geisinger Gold Secure Rx (HMO DSNP), you are automatically enrolled in a program called “Value Based Insurance Design” VBID. Because you receive “Extra Help” from Medicare, this program removes any out-of-pocket cost on your Part D prescription drug benefit, and you pay nothing for your prescriptions. **NOTE: The Value Based Insurance Design program is not applicable to any prescription drugs you might receive under your Pennsylvania Medical Assistance (Medicaid) benefit.**

SECTION 9 Part D Vaccines. What you pay for depends on how and where you get them

Our plan provides coverage for a number of Part D vaccines and vaccines covered under medical benefits. **Because coverage for vaccines can be complicated, we suggest that you call Member Services prior to receiving any vaccinations if you have any concerns.**

There are two parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of **the vaccine itself**.
- The second part of coverage is for the cost of **giving you the vaccine**. (This is sometimes called the “administration” of the vaccine.)

Your costs for a Part D vaccination depend on three things:

- 1. The type of vaccine** (what you are being vaccinated for).
 - Some vaccines are considered medical benefits. (See the *Medical Benefits Chart (what is covered and what you pay)* in Chapter 4).
 - Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan’s *List of Covered Drugs (Formulary)*.
- 2. Where you get the vaccine.**
 - The vaccine itself may be dispensed by a pharmacy or provided by the doctor’s office.
- 3. Who gives you the vaccine.**
 - A pharmacist may give the vaccine in the pharmacy or another provider may give it in the doctor’s office.

What you pay at the time you get the Part D vaccination can vary depending on the circumstances and what Drug Stage you are in.

- Sometimes when you get a vaccination, you have to pay for the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get a vaccination, you will pay only your share of the cost under your Part D benefit.

Below are three examples of ways you might get a Part D vaccine.

Situation 1: You get your vaccination at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to give vaccines.)

- You will pay the pharmacy your cost-sharing for the vaccine itself which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccination at your doctor’s office.

- When you get the vaccine, you will pay for the entire cost of the vaccine itself and the cost for the provider to give it to you.

- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7.
- You will be reimbursed the amount you paid less your normal cost-sharing for the vaccine (including administration).

Situation 3: You buy the Part D vaccine itself at your pharmacy, and then take it to your doctor's office where they give you the vaccine.

- You will have to pay the pharmacy your cost-sharing for the vaccine itself.
- When your doctor gives you the vaccine, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- You will be reimbursed the amount charged by the doctor for administering the vaccine.

CHAPTER 7:

*Asking us to pay our share of a bill
you have received for covered
medical services or drugs*

Chapter 7 Asking us to pay our share of a bill you have received for covered medical services or drugs

SECTION 1 Situations in which you should ask us to pay for your covered services or drugs

Our network providers bill (Medicare & Medicaid) the plans directly for your covered services and drugs – you should not receive a bill for covered services or drugs. If you get a bill for medical care or drugs you have received, you should send this bill to us so that we can pay it. When you send us the bill, we will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

If you have already paid for a Medicare service or item covered by the plan, you can ask our plan to pay you back (paying you back is often called “reimbursing” you). It is your right to be paid back by our plan whenever you’ve paid more than your share of the cost for medical services or drugs that are covered by our plan. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter. When you send us a bill you have already paid, we will look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we will pay you back for the services or drugs.

There may also be times when you get a bill from a provider for the full cost of medical care you have received or possibly for more than your share of cost sharing as discussed in this document. First try to resolve the bill with the provider. If that does not work, send the bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly. If we decide not to pay it, we will notify the provider. You should never pay more than plan-allowed cost-sharing. If this provider is contracted you still have the right to treatment.

Please note that your Pennsylvania Medical Assistance (Medicaid) benefit pays the Medicare cost sharing on your behalf for your Secure Rx (HMO D-SNP) Medicare-covered benefits. Geisinger Gold is not allowed to reimburse members for Pennsylvania Medical Assistance (Medicaid) covered benefits. If you have questions, please contact Member Services.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received:

1. When you’ve received emergency or urgently needed medical care from a provider who is not in our plan’s network

You can receive emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases, ask the provider to bill the plan.

- If you pay the entire amount yourself at the time you receive the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- You may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.

Chapter 7 Asking us to pay our share of a bill you have received for covered medical services or drugs

- If the provider is owed anything, we will pay the provider directly.
- If you have already paid more than your share of the cost for the service, we will determine how much you owed and pay you back for our share of the cost.

2. When a network provider sends you a bill you think you should not pay

Network providers should always bill the plan directly. But sometimes they make mistakes and ask you to pay for your services.

- We do not allow providers to bill you for covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.
- Whenever you get a bill from a network provider, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, send us the bill along with documentation of any payment you have made. You should ask us to pay you back for your covered services.

Geisinger Gold is not allowed to reimburse members for Pennsylvania Medical Assistance (Medicaid) covered benefits. If you have questions, please contact Member Services.

3. If you are retroactively enrolled in our plan

Sometimes a person's enrollment in the plan is retroactive. (This means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork such as receipts and bills for us to handle the reimbursement.

4. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. See Chapter 5, Section 2.5 for a discussion of these circumstances.

5. When you pay the full cost for a prescription because you don't have your plan membership card with you

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the

Chapter 7 Asking us to pay our share of a bill you have received for covered medical services or drugs

prescription yourself. Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

6. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost of the drug.

When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide it should be covered, we will pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 9 of this document has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or to pay a bill you have received

Section 2.1	How and where to send us your request for payment
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You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your claim to us within three (3) years** of the date you received the service, item, or drug.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it will help us process the information faster. You must include an itemized bill of services, the provider's information, name address, and proof of payment.
- Either download a copy of the form from our website (www.GeisingerGold.com) or call Member Services and ask for the form.

Mail your request for payment together with any bills or paid receipts to us at this address:

Chapter 7 Asking us to pay our share of a bill you have received for covered medical services or drugs

Medical Care Reimbursement Requests:

Geisinger Health Plan
P.O. Box 853910
Richardson, TX 75085-3910

Drug Reimbursement Requests:

Geisinger Health Plan
Attn: Pharmacy Department
100 N Academy Ave
Danville, PA 17822-3446

SECTION 3 We will consider your request for payment and say yes or no

Section 3.1	We check to see whether we should cover the service or drug and how much we owe
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When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the medical care or drug is covered and you followed all the rules, we will pay for our share of the cost for the service. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider.
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost of the care or drug. We will send you a letter explaining the reasons why we are not sending the payment and your rights to appeal that decision.

Section 3.2	If we tell you that we will not pay the medical care or drug, you can make an appeal
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If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 9 of this document.

CHAPTER 8:

Your rights and responsibilities

SECTION 1 Our plan must honor your rights as a member of the plan

Section 1.1	We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, in braille, in audio, in large print, or other alternate formats, etc.)
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Our plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how a plan may meet these accessibility requirements include, but are not limited to provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in braille, in audio, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services.

Our plan is required give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

If providers in the plan's network for a specialty are not available, it is the plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you will only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in the plan's network that cover a service you need, call the plan for information on where to go to obtain this service at in-network cost sharing.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Member Services. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

Section 1.2	We must treat you with fairness and respect at all times
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Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

Chapter 8 Your rights and responsibilities

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

Section 1.3	We must ensure that you get timely access to providers and pharmacies for your covered services and drugs
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You have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral. We do not require you to get referrals to go to network providers.

You have the right to get appointments and covered services from the plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 tells what you can do.

Section 1.4	We must protect the privacy of your personal health information
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Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you have given legal power to make decisions for you first.*

Chapter 8 Your rights and responsibilities

- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
 - We are required to release health information to government agencies that are checking on quality of care.
 - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Member Services.

Section 1.5 We must give you information about the plan, its network of providers, and your covered services

As a member of Geisinger Gold Secure Rx (HMO D-SNP), you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Member Services:

- **Information about our plan.** This includes, for example, information about the plan's financial condition.
- **Information about our network providers and pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services. Chapters 5 and 6 provide information about Part D prescription drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical

service or Part D drug is not covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

Section 1.6	We must support your right to make decisions about your care, regardless of cost or whether covered by your plan, as well as your right to use advance directives and/or name an authorized representative to help with your decisions
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You have the right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your doctors and other health care providers. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say “no.”** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** abo

Chapter 8 Your rights and responsibilities

- ut how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called “**advance directives**.” There are different types of advance directives and different names for them. Documents called “**living will**” and “**power of attorney for health care**” are examples of advance directives.

If you want to use an “advance directive” to give your instructions, here is what to do:

- **Get the form.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can’t. You may want to give copies to close friends or family members. Keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**

- The hospital will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the Pennsylvania Insurance Department, Bureau of Consumer Services, 1209 Strawberry Square, Harrisburg, PA 17120.

Section 1.7	You have the right to make complaints and to ask us to reconsider decisions we have made
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If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 9 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

Section 1.8	What can you do if you believe you are being treated unfairly or your rights are not being respected?
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If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, sexual orientation, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697 or call your local Office for Civil Rights.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, *and it's not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Member Services**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).
- Or, you can call Pennsylvania Medical Assistance (Medicaid), the State Ombudsman programs or your Community HealthChoices Plan at the contact numbers listed in Chapter 2, Section 6 of this document.

Section 1.9	How to get more information about your rights or make recommendations regarding Geisinger Gold's Rights and Responsibilities Policy
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There are several places where you can get more information about your rights:

- You can **call Member Services**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- You can contact **Medicare**.
 - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
 - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

SECTION 2 You have some responsibilities as a member of the plan

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this Evidence of Coverage to learn what is covered for you and the rules you need to follow to get your covered services.
 - Chapters 3 and 4 give the details about your medical services.
 - Chapters 5 and 6 give the details about your Part D prescription drug coverage.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
 - We are required to follow rules set by Medicare and Pennsylvania Medical Assistance (Medicaid) to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called “**coordination of benefits**” because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We’ll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
 - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have any questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor’s office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
 - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. For most Geisinger Gold Secure Rx (HMO D-SNP) members, Pennsylvania Medical Assistance (Medicaid) pays for your Part A premium (if

Chapter 8 Your rights and responsibilities

you don't qualify for it automatically) and for your Part B premium. If Pennsylvania Medical Assistance (Medicaid) is not paying your Medicare premiums for you must continue to pay your Medicare premiums to remain a member of the plan.

- You must continue to pay your Medicare premiums to remain a member of the plan.
- If you are required to pay the extra amount for Part D because of your higher income (as reported on your last tax return), you must continue to pay the extra amount directly to the government to remain a member of the plan.
- **If you move *within* our service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of our plan service area, you cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

CHAPTER 9:

*What to do if you have a problem
or complaint (coverage decisions,
appeals, complaints)*

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on two things:

1. Whether your problem is about benefits covered by **Medicare** or **Pennsylvania Medical Assistance (Medicaid)**. If you would like help deciding whether to use the Medicare process or the Pennsylvania Medical Assistance (Medicaid) process, or both, please contact Member Services.
2. The type of problem you are having:
 - For some problems, you need to use the **process for coverage decisions and appeals**.
 - For other problems, you need to use the **process for making complaints**; also called grievances.

These processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The guide in Section 3 will help you identify the right process to use and what you should do.

Section 1.2 What about the legal terms?

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand. To make things easier, this chapter:

- Uses simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “organization determination” or “coverage determination” or “at-risk determination,” and “independent review organization” instead of “Independent Review Entity.”
- It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms. Knowing which terms to use will help you communicate more accurately to get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 2 Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to customer service for help. But in some situations you may also want help or guidance from someone who is not connected with us. Below are four entities that can assist you.

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers and website URLs in Chapter 2, Section 3 of this document.

Medicare

You can also contact Medicare to get help. To contact Medicare:

- 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.
- You can also visit the Medicare website (www.medicare.gov).

You can get help and information from Pennsylvania Medical Assistance (Medicaid)

For more information about your Pennsylvania Medical Assistance (Medicaid) benefits or for help in handling a problem with your Pennsylvania Medical Assistance (Medicaid) benefits, contact your local County Assistance Office. A list of County Assistance Offices and their phone numbers can be found in Chapter 2, Section 6 of this document. You may also contact Pennsylvania Medical Assistance (Medicaid) directly at 1-800-692-7462 between 8:30 a.m. and 5:00 p.m., Monday through Friday or visit their website at: www.dhs.pa.gov/Services/Assistance/Pages/Medical-Assistance.aspx. Or you may contact your Community HealthChoices Plan.

You can get help and information from the Pennsylvania Quality Improvement Organization (QIO)

If you have concerns about the quality of care you have received or if you think coverage for your hospital stay, Skilled Nursing Facility Care or if you believe your Outpatient Rehabilitation Services are ending too soon, you can contact your Quality Improvement Organization for assistance. Contact information can be found in Chapter 2, section 4 of this document.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 3 To deal with your problem, which process should you use?

Because you have Medicare and get assistance from Pennsylvania Medical Assistance (Medicaid), you have different processes that you can use to handle your problem or complaint. Which process you use depends on whether the problem is about Medicare benefits or Pennsylvania Medical Assistance (Medicaid) benefits. If your problem is about a benefit covered by Medicare, then you should use the Medicare process. If your problem is about a benefit covered by Pennsylvania Medical Assistance (Medicaid), then you should use the Pennsylvania Medical Assistance (Medicaid) process. If you would like help deciding whether to use the Medicare process or the Pennsylvania Medical Assistance (Medicaid) process, please contact Member Services.

The Medicare process and Pennsylvania Medical Assistance (Medicaid) process are described in different parts of this chapter. To find out which part you should read, use the chart below.

Is your problem about Medicare benefits or Pennsylvania Medical Assistance (Medicaid) benefits?

If you would like help deciding whether your problem is about Medicare benefits or Pennsylvania Medical Assistance (Medicaid) benefits, please contact Member Services.

My problem is about **Medicare** benefits.

Go to the next section of this chapter, **Section 4, “Handling problems about your Medicare benefits.”**

My problem is about **Pennsylvania Medical Assistance (Medicaid)** coverage.

Skip ahead to **Section 12** of this chapter, **“Handling problems about your Pennsylvania Medical Assistance (Medicaid) benefits.”**

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

PROBLEMS ABOUT YOUR MEDICARE BENEFITS

SECTION 4 Handling problems about your Medicare benefits

Section 4.1	Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?
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If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The chart below will help you find the right section of this chapter for problems or complaints about **benefits covered by Medicare**.

To figure out which part of this chapter will help with your problem or concern about your **Medicare** benefits, use this chart:

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care or prescription drugs are covered or not, the way they are covered, and problems related to payment for medical care or prescription drugs.

Yes.

Go on to the next section of this chapter, **Section 5, “A guide to the basics of coverage decisions and appeals.”**

No.

Skip ahead to **Section 11** at the end of this chapter: **“How to make a complaint about quality of care, waiting times, customer service, or other concerns.”**

SECTION 5 A guide to the basics of coverage decisions and appeals

Section 5.1	Asking for coverage decisions and making appeals: the big picture
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Coverage decisions and appeals deal with problems related to your benefits and coverage, including payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Asking for coverage decisions prior to receiving services

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide a service or drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

If your doctor, whether in-network or out-of-network, is unsure whether we will cover a medical service, you or your doctor can contact us and ask for a coverage decision prior to receiving the service. This is called an "advanced determination" or prior authorization. You or your doctor can also request that the response be in writing if you would like a copy of the decision for your records. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make an initial coverage decision for you. If your plan denies the coverage asked about in the advanced determination, then your plan must issue a standardized denial notice informing you or your doctor of your right to appeal this decision.

If you do not have an advanced determination, authorization for services can also be obtained from a network provider who refers an enrollee to a specialist. This can also be a provider outside of the plan's network. However, the service cannot be a service that is explicitly excluded from plan coverage (that is, never covered by the plan) as discussed in Chapter 4. If the enrollee receives an authorization from the provider and the service is not an excluded service, the enrollee only has to pay plan-cost sharing. If the plan attempts to charge the enrollee more, the enrollee can formally request a review called an appeal. This is discussed in the next section.

In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal. This review is a formal process called an appeal. Appeals are discussed in the next section.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Making an appeal

If we make a coverage decision and you are not satisfied, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or “fast appeal” of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we were properly following the rules. When we have completed the review, we give you our decision.

In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won’t review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn’t legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 appeal, your appeal will automatically go on to Level 2. The Level 2 appeal is conducted by an independent review organization that is not connected to us.

- You do not need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal to Level 2 if we do not fully agree with your Level 1 appeal.
- See **Section 6.4** of this chapter for more information about Level 2 appeals.

If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 10 in this chapter explains the Level 3, 4, and 5 appeals processes).

Section 5.2	How to get help when you are asking for a coverage decision or making an appeal
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Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Member Services**.
- You **can get free help** from your State Health Insurance Assistance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Member Services and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf)
 - For medical care, your doctor can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
 - If you want a friend, relative, or other person to be your representative, call Member Services and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at (www.GeisingerGold.com)). The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
 - While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 5.3	Which section of this chapter gives the details for your situation?
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There are four different situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 6** of this chapter: “Your medical care: How to ask for a coverage decision or make an appeal”
- **Section 7** of this chapter: “Your Part D prescription drugs: How to ask for a coverage decision or make an appeal”
- **Section 8** of this chapter: “How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon”
- **Section 9** of this chapter: “How to ask us to keep covering certain medical services if you think your coverage is ending too soon” (*Applies only to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services*)

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

If you're not sure which section you should be using, please call Member Services. You can also get help or information from government organizations such as your State Health Insurance Assistance Program.

SECTION 6 Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision

Section 6.1	This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for your care
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This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this document: *Medical Benefits Chart (what is covered)*. To keep things simple, we generally refer to “medical care coverage” or “medical care” which includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan. **Ask for a coverage decision. Section 6.2.**
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan. **Ask for a coverage decision. Section 6.2.**
3. You have received medical care that you believe should be covered by the plan, but we have said we will not pay for this care. **Make an appeal. Section 6.3.**
4. You have received and paid for medical care that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 6.5.**
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 6.3.**

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read Sections 7 and 8 of this Chapter. Special rules apply to these types of care.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**Section 6.2 Step-by-step: How to ask for a coverage decision****Legal Terms**

When a coverage decision involves your medical care, it is called an “**organization determination.**”

A “fast coverage decision” is called an “**expedited determination.**”

Step 1: Decide if you need a “standard coverage decision” or a “fast coverage decision.”

A “standard coverage decision” is usually made within 14 days or 72 hours for Part B drugs. A “fast coverage decision” is generally made within 72 hours, for medical services, 24 hours for Part B drugs. In order to get a fast coverage decision, you must meet two requirements:

- You may *only* ask for coverage for medical care *you have not yet received*.
- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor’s support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
 - Explains that we will use the standard deadlines
 - Explains if your doctor asks for the fast coverage decision, we will automatically give you a fast coverage decision
 - Explains that you can file a “fast complaint” about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

Step 2: Ask our plan to make a coverage decision or fast coverage decision.

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.

For standard coverage decisions we use the standard deadlines.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

This means we will give you an answer within 14 calendar days after we receive your request for a medical item or service. If your request is for a **Medicare Part B prescription drug**, we will give you an answer **within 72 hours** after we receive your request.

- **However**, if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a "fast complaint". We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. See Section 11 of this chapter for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours.

- **However**, if you ask for more time, or if we need more that may benefit you **we can take up to 14 more days**. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a "fast complaint". (See Section 11 of this chapter for information on complaints.) We will call you as soon as we make the decision.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 4: If we say no to your request for coverage for medical care, you can appeal.

If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**Section 6.3 Step-by-step: How to make a Level 1 appeal****Legal Terms**

An appeal to the plan about a medical care coverage decision is called a plan **“reconsideration.”**

A “fast appeal” is also called an **“expedited reconsideration.”**

Step 1: Decide if you need a “standard appeal” or a “fast appeal.”

A “standard appeal” is usually made within 30 days. A “fast appeal” is generally made within 72 hours.

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a “fast appeal.” If your doctor tells us that your health requires a “fast appeal,” we will give you a fast appeal.
- The requirements for getting a “fast appeal” are the same as those for getting a “fast coverage decision” in Section 6.2 of this chapter.

Step 2: Ask our plan for an appeal or a Fast appeal

- **If you are asking for a standard appeal, submit your standard appeal in writing.** Chapter 2 has contact information.
- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the request for a coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

Step 3: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take a careful look at all of the information. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if needed, possibly contacting you or your doctor.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Deadlines for a “fast appeal”

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
 - If you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time if your request is for a Medicare Part B prescription drug.
 - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

Deadlines for a “standard” appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
 - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
 - If you believe we should *not* take extra days, you can file a “fast complaint”. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (See Section 11 of this chapter for information on complaints.)
 - If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal where an independent review organization will review the appeal. Section 6.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

If our plan says no to part or all of your appeal, we will automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 6.4 Step-by-step: How a Level 2 appeal is done

Legal Term

The formal name for the “independent review organization” is the “**Independent Review Entity.**” It is sometimes called the “**IRE.**”

The **independent review organization is an independent organization hired by Medicare.** It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: The independent review organization reviews your appeal.

- We will send the information about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.**
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

If you had a “fast” appeal at Level 1, you will also have a “fast” appeal at Level 2

- For the “fast appeal” the review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it receives your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.** The independent review organization can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.

If you had a “standard” appeal at Level 1, you will also have a “standard” appeal at Level 2

- For the “standard appeal” if your request is for a medical item or service, the review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it receives your appeal.
- If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it receives your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more**

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

calendar days. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

Step 2: The independent review organization gives you their answer.

The independent review organization will tell you its decision in writing and explain the reasons for it.

- **If the independent review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage **within 72 hours** or provide the service within **14 calendar days** after we receive the independent review organization's decision for **standard requests** or provide the service **within 72 hours** from the date the plan receives the independent review organization's decision for **expedited requests**.
- **If the independent review organization says yes to part or all of a request for a Medicare Part B prescription drug,** we must authorize or provide the Medicare Part B prescription drug **within 72 hours** after we receive the independent review organization's decision for **standard requests** or **within 24 hours** from the date we receive the independent review organization's decision for **expedited requests**.
- **If this organization says no to part or all of your appeal,** it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision" or "turning down your appeal.") In this case, the independent review organization will send you a letter:
 - Explaining its decision.
 - Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage you are requesting meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
 - Telling you how to file a Level 3 appeal.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 in this chapter explains the Levels 3, 4, and 5 appeals processes.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Section 6.5 What if you are asking us to pay you back for our share of a bill you have received for medical care?

We can't reimburse you directly for a Pennsylvania Medical Assistance (Medicaid) service or item. If you get a bill for Pennsylvania Medical Assistance (Medicaid)-covered services and items, send the bill to us. **You should not pay the bill yourself.** We will contact the provider directly and take care of the problem. But if you do pay the bill, you can get a refund from that health care provider if you followed the rules for getting the service or item.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you are asking for a coverage decision. To make this decision, we will check to see if the medical care you paid for is a covered service. We will also check to see if you followed all the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed all the rules, we will send you the payment for our share of the cost within 60 calendar days after we receive your request. If you haven't paid for the services, we will send the payment directly to the provider.
- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why.

If you do not agree with our decision to turn you down, **you can make an appeal.** If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in Section 5.3. For appeals concerning reimbursement, please note:

- We must give you our answer within 60 calendar days after we receive your appeal. If you are asking us to pay you back for medical care you have already received and paid for, you are not allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 7 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Section 7.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (See Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs please see Chapters 5 and 6. **This section is about your Part D drugs only.** To keep things simple, we generally say “drug” in the rest of this section, instead of repeating “covered outpatient prescription drug” or “Part D drug” every time. We also use the term “drug list” instead of “List of Covered Drugs” or “Formulary.”

- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we will cover it.
- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Term

An initial coverage decision about your Part D drugs is called a **“coverage determination.”**

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. This section tells what you can do if you are in any of the following situations:

- Asking to cover a Part D drug that is not on the plan’s *List of Covered Drugs*. **Ask for an exception. Section 7.2**
- Asking to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get) **Ask for an exception. Section 7.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 7.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 7.4**

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**Section 7.2 What is an exception?****Legal Terms**

Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **“formulary exception.”**

Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **“formulary exception.”**

Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **“tiering exception.”**

If a drug is not covered in the way you would like it to be covered, you can ask us to make an “exception.” An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are two examples of exceptions that you or your doctor or other prescriber can ask us to make:

- 1. Covering a Part D drug for you that is not on our Drug List.** If we agree to cover a drug not on the Drug List, you will need to pay the cost-sharing amount that applies to all of our drugs. You cannot ask for an exception to the cost-sharing amount we require you to pay for the drug.
- 2. Removing a restriction for a covered drug.** Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List.

Section 7.3 Important things to know about asking for exceptions**Your doctor must tell us the medical reasons**

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.

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- If we say no to your request, you can ask for another review of our decision by making an appeal.

Section 7.4	Step-by-step: How to ask for a coverage decision, including an exception
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Legal Term

A “fast coverage decision” is called an “ expedited coverage determination. ”
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Step 1: Decide if you need a “standard coverage decision” or a “fast coverage decision.”

“**Standard coverage decisions**” are made within **72 hours** after we receive your doctor’s statement. “**Fast coverage decisions**” are made within **24 hours** after we receive your doctor’s statement.

If your health requires it, ask us to give you a “fast coverage decision.” To get a fast coverage decision, you must meet two requirements:

- You must be asking for a *drug you have not yet received*. (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor or other prescriber tells us that your health requires a “fast coverage decision,” we will automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber’s support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
 - Explains that we will use the standard deadlines.
 - Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
 - Tells you how you can file a “fast complaint” about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.

Step 2: Request a “standard coverage decision” or a “fast coverage decision.”

Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the CMS Model

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Coverage Determination Request Form available on our website. Chapter 2 has contact information. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 5.2 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you are requesting an exception, provide the “supporting statement,”** which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

Step 3: We consider your request and give you our answer.

Deadlines for a “fast coverage decision”

- We must generally give you our answer **within 24 hours** after we receive your request.
 - For exceptions, we will give you our answer within 24 hours after we receive your doctor’s supporting statement. We will give you our answer sooner if your health requires us to.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor’s statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a “standard” coverage decision about a drug you have not yet received

- We must generally give you our answer **within 72 hours** after we receive your request.
 - For exceptions, we will give you our answer within 72 hours after we receive your doctor’s supporting statement. We will give you our answer sooner if your health requires us to.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor’s statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Deadlines for a “standard” coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

Section 7.5	Step-by-step: How to make a Level 1 appeal
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Legal Terms
<p>An appeal to the plan about a Part D drug coverage decision is called a plan “redetermination.”</p> <p>A “fast appeal” is also called an “expedited redetermination.”</p>

Step 1: Decide if you need a “standard appeal” or a “fast appeal.”

A “standard appeal” is usually made within 7 days. A “fast appeal” is generally made within 72 hours. If your health requires it, ask for a “fast appeal”

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast coverage decision” in Section 7 of this chapter.

Step 2: You, your representative, doctor or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a “fast appeal.”

- **For standard appeals, submit a written request.** Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at (1-800-498-9731).** Chapter 2 has contact information.

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- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal.

Step 3: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a “fast appeal”

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
 - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 7 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a “standard” appeal for a drug you have not yet received

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
 - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 7 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we receive your appeal. **If our answer is no to part or all of what you requested**, we will

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a “standard appeal” about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Section 7.6	Step-by-step: How to make a Level 2 appeal
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Legal Term
The formal name for the “independent review organization” is the “ Independent Review Entity. ” It is sometimes called the “ IRE. ”

The formal name for the “independent review organization” is the “**Independent Review Entity.**” It is sometimes called the “**IRE.**”

The **independent review organization is an independent organization hired by Medicare.** It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization. If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding “at-risk” determination under our drug management program, we will automatically forward your claim to the IRE.
- We will send the information about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.**

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

Deadlines for “fast” appeal

- If your health requires it, ask the independent review organization for a “fast appeal.”
- If the organization agrees to give you a “fast appeal,” the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

Deadlines for “standard” appeal

- For standard appeals, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not yet received. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your request.

Step 3: The independent review organization gives you their answer.

For “fast appeals”:

- **If the independent review organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

For “standard appeals”:

- **If the independent review organization says yes to part or all of your request for coverage,** we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to part or all of your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called “upholding the decision.” It is also called “turning down your appeal.”). In this case, the independent review organization will send you a letter:

- Explaining its decision.

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- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If
- you want to go on to Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 of this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will help arrange for care you may need after you leave.

- The day you leave the hospital is called your “**discharge date**.”
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

Section 8.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

Within two days of being admitted to the hospital, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, please call Member Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don’t understand it.** It tells you:

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
 - Your right to be involved in any decisions about your hospital stay
 - Where to report any concerns you have about quality of your hospital care
 - Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.
- 2. You will be asked to sign the written notice to show that you received it and understand your rights.**
- You or someone who is acting on your behalf will be asked to sign the notice.
 - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does not mean** you are agreeing on a discharge date.
- 3. Keep your copy** of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.
- If you sign the notice more than two days before your discharge date, you will get another copy before you are scheduled to be discharged.
 - To look at a copy of this notice in advance, you can call Member Services or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices.

Section 8.2**Step-by-step: How to make a Level 1 appeal to change your hospital discharge date**

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts are not part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge**.
 - **If you meet this deadline**, you may stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
 - **If you do *not* meet this deadline**, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 8.4 of this chapter.

Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

You can get a sample of the Detailed Notice of Discharge by calling Member Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices.

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Step 2: The Quality Improvement Organization conducts an independent review of your case.

- Health professionals at the Quality Improvement Organization (“the reviewers”) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers told us of your appeal, you will get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.*What happens if the answer is yes?*

- If the review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the review organization says *no*, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to “Level 2” of the appeals process.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Section 8.3 Step-by-step: How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at their decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you their decision.***If the review organization says yes:***

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.

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- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 of this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8.4 What if you miss the deadline for making your Level 1 appeal?

Legal Term

A “fast” review (or “fast appeal”) is also called an “**expedited appeal.**”

You can appeal to us instead

As explained above, you must act quickly to start your Level 1 appeal of your hospital discharge. If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* appeal

Step 1: Contact us and ask for a “fast review.”

- **Ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines. Chapter 2 has contact information.

Step 2: We do a “fast” review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We see if the decision about when you should leave the hospital was fair and followed all the rules.

Step 3: We give you our decision within 72 hours after you ask for a “fast review”.

- **If we say yes to your appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date. We will keep providing your covered inpatient hospital services for as long as they are medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
 - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

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Step 4: If we say *no* to your appeal, your case will *automatically* be sent on to the next level of the appeals process.

Step-by-Step: Level 2 *Alternate* appeal Process

Legal Term
The formal name for the “independent review organization” is the “ Independent Review Entity. ” It is sometimes called the “ IRE. ”

The **independent review organization is an independent organization hired by Medicare.** It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: We will automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 11 of this chapter tells how to make a complaint.)

Step 2: The independent review organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then we must (pay you back) for our share of the costs of hospital care you received since the date of your planned discharge. We must also continue the plan’s coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree that your planned hospital discharge date was medically appropriate.
 - The written notice you get from the independent review organization will tell how to start a Level 3 appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 3: If the independent review organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 appeal, you decide whether to accept their decision or go on to Level 3 appeal.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- Section 10 of this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 9.1 *This section is about three services only:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

When you are getting **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care.*

If you think we are ending the coverage of your care too soon, **you can appeal our decision.** This section tells you how to ask for an appeal.

Section 9.2 We will tell you in advance when your coverage will be ending

Legal Term

“Notice of Medicare Non-Coverage.” It tells you how you can request a **“fast-track appeal.”** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care.

1. **You receive a notice in writing** at least two days before our plan is going to stop covering your care. The notice tells you:
 - The date when we will stop covering the care for you.
 - How to request a “fast track appeal” to request us to keep covering your care for a longer period of time.
2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you received it.** Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan’s decision to stop care.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Section 9.3 Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a fast-track appeal. You must act quickly.***How can you contact this organization?***

- The written notice you received (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.)

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the Notice of Medicare Non-Coverage.

Your deadline for contacting this organization.

- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 9.5 of this chapter.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Step 2: The Quality Improvement Organization conducts an independent review of your case.

Legal Term
“Detailed Explanation of Non-Coverage.” Notice that provides details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization (“the reviewers”) will ask you, or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers tell us of your appeal, you will get the **Detailed Explanation of Non-Coverage** from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say *no*, then **your coverage will end on the date we have told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say *no* to your Level 1 appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Section 9.4 Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.***What happens if the review organization says yes?***

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

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Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 of this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 9.5 What if you miss the deadline for making your Level 1 appeal?

You can appeal to us instead

As explained above, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* appeal

Legal Term

A “fast review” (or “fast appeal”) is also called an “**expedited appeal.**”

Step 1: Contact us and ask for a “fast review.”

- **Ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines. Chapter 2 has contact information.

Step 2: We do a “fast review” of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan’s coverage for services you were receiving.

Step 3: We give you our decision within 72 hours after you ask for a “fast review”.

- **If we say yes to your appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care.

Step 4: If we say *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

Legal Term
The formal name for the “independent review organization” is the “ Independent Review Entity. ” It is sometimes called the “ IRE. ”

Step-by-Step: Level 2 *Alternate* appeal Process

During the Level 2 appeal, the **independent review organization** reviews the decision we made to your “fast appeal.” This organization decides whether the decision should be changed. **The independent review organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the independent review organization. Medicare oversees its work.

Step 1: We automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 11 of this chapter tells how to make a complaint.)

Step 2: The independent review organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal**, then we must pay you back for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover services.
- **If this organization says *no* to your appeal**, it means they agree with the decision our plan made to your first appeal and will not change it.
- The notice you get from the independent review organization will tell you in writing what you can do if you wish to go on to a Level 3 appeal.

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Step 3: If the independent review organization says no to your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- A Level 3 appeal is reviewed by an Administrative Law Judge or attorney adjudicator. Section 10 of this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 10 Taking your appeal to Level 3 and beyond

Section 10.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal An Administrative Law Judge or an attorney adjudicator who works for the Federal government will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may or may not* be over** -. Unlike a decision at Level 2 appeal we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal it will go to a Level 4 appeal.
 - If we decide *not* to appeal, we must authorize or provide you with the service within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
 - If we decide to appeal the decision, we will send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may or may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.

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- If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal: The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Council's decision.
 - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Section 10.2 Appeal Levels 3, 4 and 5 for Part D Drug Requests

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

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Level 3 appeal An Administrative Law Judge or attorney adjudicator who works for the Federal government will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 appeal A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 11 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 11.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	<ul style="list-style-type: none"> • Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	<ul style="list-style-type: none"> • Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	<ul style="list-style-type: none"> • Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • Do you feel you are being encouraged to leave the plan?
Waiting times	<ul style="list-style-type: none"> • Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at the plan? <ul style="list-style-type: none"> ○ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	<ul style="list-style-type: none"> • Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	<ul style="list-style-type: none"> • Did we fail to give you a required notice? • Is our written information hard to understand?

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Complaint	Example
<p>Timeliness (These types of complaints are all related to the <i>timeliness</i> of our actions related to coverage decisions and appeals)</p>	<p>If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples:</p> <ul style="list-style-type: none"> • You asked us for a “fast coverage decision” or a “fast appeal,” and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain medical services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 11.2 How to make a complaint

Legal Terms
<ul style="list-style-type: none"> • A “Complaint” is also called a “grievance.” • “Making a complaint” is also called “filing a grievance.” • “Using the process for complaints” is also called “using the process for filing a grievance.” • A “fast complaint” is also called an “expedited grievance.”

Section 11.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- **Complaint (Grievance) Review Procedure:**

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- If Member Services is unable to respond to your complaint on the telephone or if we receive your complaint in writing, the Geisinger Gold Member Resolution Team will respond to your complaint as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for an extension, or if we justify a need for additional information and the delay is in your best interest. When we extend the deadline, we will notify you in writing of the reasons for the delay. Each complaint will be investigated and an oral or written response will be provided to you that will include the basis for the decision.
- You also have the right to ask Geisinger Gold for a copy of your file that contains the information regarding your complaint. For a copy of your file, you can call us toll free at 1-866-577-7733, press option “0”, or send a written request to the Geisinger Gold Member Resolution Team, 100 North Academy Avenue, Danville, PA 17822-3220.
- **Expedited (Fast) Grievances**
 - As a Geisinger Gold member, you have the right to file an expedited (fast) grievance for services you have not yet received.
 - You may file an expedited (fast) grievance if the plan denies your request for an expedited organization determination, expedited reconsideration (appeal), expedited coverage decision or expedited redetermination (appeal).
 - You may also file an expedited (fast) grievance if you disagree with the plan’s decision to take an extension to process an expedited or standard organization determination or an expedited or standard reconsideration (appeal).
- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast complaint.”** If you have a “fast complaint,” it means we will give you **an answer within 24 hours.**
- **If we do not agree** with some or all of your complaint or don’t take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Section 11.4 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint directly to the Quality Improvement Organization.** The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 11.5 You can also tell Medicare about your complaint

You can submit a complaint about Geisinger Gold Secure Rx (HMO D-SNP) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

PROBLEMS ABOUT YOUR PENNSYLVANIA MEDICAL ASSISTANCE (MEDICAID) BENEFITS

SECTION 12 Handling problems about your Pennsylvania Medical Assistance (Medicaid) benefits

Contact your local County Assistance Office for help with your Pennsylvania Medical Assistance (Medicaid) benefits.

Geisinger Gold does not provide or administer your Pennsylvania Medical Assistance (Medicaid) benefits. Your Community HealthChoices Plan provides and administers your Pennsylvania Medical Assistance (Medicaid) benefits. If you would like help deciding if a problem or concern is about a Pennsylvania Medical Assistance (Medicaid) benefit or a Geisinger Gold Secure Rx (HMO D-SNP) benefit, please contact Geisinger Gold Member Services.

If you have a problem or concern with a Pennsylvania Medical Assistance (Medicaid) benefit, please call or visit your local County Assistance Office or your Community HealthChoices Plan. The County Assistance Office can answer your Pennsylvania Medical Assistance (Medicaid) questions and explain your Pennsylvania Medical Assistance (Medicaid) benefits. Contact information for these offices can be found in Chapter 2, Section 6 of this document.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

You may appeal any action or failure to act and you have the right to have a hearing if you are dissatisfied with any decision to refuse, discontinue, change, suspend, or reduce Pennsylvania Medical Assistance (Medicaid) services or benefits. Depending on your Pennsylvania Medical Assistance (Medicaid) benefits package you may also have other types of help available to you. Contact your County Assistance Office for more information.

If you want to appeal a decision about your Pennsylvania Medical Assistance (Medicaid) benefits, the County Assistance Office can provide you with information about the Pennsylvania Medical Assistance (Medicaid) appeals process and assist you with submitting your appeal. Generally, Pennsylvania Medical Assistance (Medicaid) appeals are submitted, in writing, to the County Assistance Office. Written appeals must be signed. Initial appeal requests may be made orally, but you will need to follow up with a signed, written appeal within three (3) working days. You have 30 days to file an appeal from the date the notice of the decision you are appealing was mailed.

For more information about the Pennsylvania Medical Assistance (Medicaid) appeals process, contact your local County Assistance Office. Contact information for your County Assistance Office can be found in Chapter 2, Section 6 of this document.

CHAPTER 10:

Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in Geisinger Gold Secure Rx (HMO D-SNP) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your medical care and prescription drugs and you will continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

Section 2.1	You may be able to end your membership because you have Medicare and Pennsylvania Medical Assistance (Medicaid)
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Most people with Medicare can end their membership only during certain times of the year. Because you have Pennsylvania Medical Assistance (Medicaid), you may be able to end your membership in our plan or switch to a different plan one time during each of the following Special Enrollment Periods:

- January to March
- April to June
- July to September

If you joined our plan during one of these periods, you'll have to wait for the next period to end your membership or switch to a different plan. You can't use this Special Enrollment Period to end your membership in our plan between October and December. However, all people with Medicare can make changes from October 15 – December 7 during the Annual Enrollment Period. Section 2.2 tells you more about the Annual Enrollment Period.

- Choose any of the following types of Medicare plans:
 - Another Medicare health plan, with or without prescription drug coverage
 - Original Medicare *with* a separate Medicare prescription drug plan
 - Original Medicare without a separate Medicare prescription drug plan
 - If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Note: If you disenroll from Medicare prescription drug coverage and go without “creditable” prescription drug coverage for a continuous period of 63 days or more,

Chapter 10 Ending your membership in the plan

you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Contact your State Pennsylvania Medical Assistance (Medicaid) Office to learn about your Pennsylvania Medical Assistance (Medicaid) plan options. You may also contact your Community HealthChoices Plan. (telephone numbers are in Chapter 2, Section 6 of this booklet).

- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plans. Your enrollment in your new plan will also begin on this day.

Section 2.2	You can end your membership during the Annual Enrollment Period
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You can end your membership during the Annual Enrollment Period (also known as the “Annual Open Enrollment Period”). During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- The **Annual Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
 - Another Medicare health plan, with or without prescription drug coverage.
 - Original Medicare *with* a separate Medicare prescription drug plan

OR

 - Original Medicare *without* a separate Medicare prescription drug plan.
- **Your membership will end in our plan** when your new plan’s coverage begins on January 1.

If you receive “Extra Help” from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Section 2.3	You can end your membership during the Medicare Advantage Open Enrollment Period
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You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period**.

Chapter 10 Ending your membership in the plan

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31.
- **During the annual Medicare Advantage Open Enrollment Period** you can:
 - Switch to another Medicare Advantage Plan with or without prescription drug coverage.
 - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.4 **In certain situations, you can end your membership during a Special Enrollment Period**

In certain situations, you may be eligible to end your membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):

- Usually when you have moved.
- If you have Pennsylvania Medical Assistance (Medicaid).
- If you are eligible for “Extra Help” with paying for your Medicare prescriptions
- If we violate our contract with you.
- If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE) (*In Pennsylvania, this program is sometimes called the Living Independence for the Elderly (LIFE) Program*)

Note: If you’re in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.

Note: Section 2.1 tells you more about the special enrollment period for people with Pennsylvania Medical Assistance (Medicaid).

- **The enrollment time periods vary** depending on your situation.
- **To find out if you are eligible for a Special Enrollment Period**, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation,

you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

- Another Medicare health plan with or without prescription drug coverage.
- Original Medicare *with* a separate Medicare prescription drug plan

OR

- Original Medicare *without* a separate Medicare prescription drug plan.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

If you receive “Extra Help” from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Your membership will usually end on the first day of the month after your request to change your plan is received.

Note: Sections 2.1 and 2.2 tell you more about the special enrollment period for people with Pennsylvania Medical Assistance (Medicaid) and Extra Help.

Section 2.5	Where can you get more information about when you can end your membership?
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If you have any questions about ending your membership you can:

- **Call Member Services**
- Find the information in the *Medicare & You 2023* handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

SECTION 3 **How do you end your membership in our plan?**

The table below explains how you should end your membership in our plan.

Chapter 10 Ending your membership in the plan

If you would like to switch from our plan to:	This is what you should do:
Another Medicare health plan	<ul style="list-style-type: none"> • Enroll in the new Medicare health plan. Your new coverage will begin on the first day of the following month. • You will automatically be disenrolled from Geisinger Gold Secure Rx (HMO D-SNP) when your new plan's coverage begins.
Original Medicare <i>with</i> a separate Medicare prescription drug plan	<ul style="list-style-type: none"> • Enroll in the new Medicare prescription drug plan. Your new coverage will begin on the first day of the following month. • You will automatically be disenrolled from Geisinger Gold Secure Rx (HMO D-SNP) when your new plan's coverage begins.
Original Medicare <i>without</i> a separate Medicare prescription drug plan <ul style="list-style-type: none"> ○ If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment. ○ If you disenroll from Medicare prescription drug coverage and go 63 days or more in a row without creditable prescription drug coverage, you may have to pay a late enrollment penalty if you join a Medicare drug plan later. 	<ul style="list-style-type: none"> • Send us a written request to disenroll • Contact Member Services if you need more information on how to do this. • You can also 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. • You will be disenrolled from Geisinger Gold Secure Rx (HMO D-SNP) when your coverage in Original Medicare begins.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

For questions about your Pennsylvania Medical Assistance (Medicaid) benefits, contact Pennsylvania Medical Assistance (Medicaid) at 1-800-692-7462, Monday – Friday 8:30 a.m. – 5:00 p.m.; TTY users can call 1-800-451-5886. You may also contact your Community HealthChoices Plan at the phone number listed in chapter 2, Section 6 of this document. Ask how joining another plan or returning to Original Medicare affects how you get your Pennsylvania Medical Assistance (Medicaid) coverage. Ask how joining another plan or

Chapter 10 Ending your membership in the plan

returning to Original Medicare affects how you get your Pennsylvania Medical Assistance (Medicaid) coverage.

SECTION 4 Until your membership ends, you must keep getting your medical services and drugs through our plan

Until your membership in Geisinger Gold Secure Rx (HMO D-SNP) ends, and your new Medicare coverage begins, you must continue to get your medical care and prescription drugs through our plan.

- **Continue to use our network providers to receive medical care.**
- **Continue to use our network pharmacies *or mail-order service* to get your prescriptions filled.**
- **If you are hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 Geisinger Gold Secure Rx (HMO D-SNP) must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

Geisinger Gold Secure Rx (HMO D-SNP) must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B
- If you are no longer eligible for Pennsylvania Medical Assistance (Medicaid). As stated in Chapter 1, Section 2.1, our plan is for people who are eligible for both Medicare and Pennsylvania Medical Assistance (Medicaid). If you no longer meet the special eligibility requirements of our plan, your membership in this plan will end after six months. You will receive a notice from us informing you of the end of your membership and your options. If you have any questions about your eligibility, please contact Member Services.
- If you move out of our service area
- If you are away from our service area for more than six months
 - If you move or take a long trip, call Member Services to find out if the place you are moving or traveling to is in our plan's service area.
- If you become incarcerated (go to prison)
- If you are no longer a United States citizen or lawfully present in the United States

Chapter 10 Ending your membership in the plan

- If you lie or withhold information about other insurance you have that provides prescription drug coverage
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan

Where can you get more information?

If you have questions or would like more information on when we can end your membership call Member Services.

Section 5.2	We <u>cannot</u> ask you to leave our plan for any health-related reason
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Geisinger Gold Secure Rx (HMO D-SNP) is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Section 5.3	You have the right to make a complaint if we end your membership in our plan
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If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 11:

Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

SECTION 2 Notice about nondiscrimination

Our plan must obey laws that protect you from discrimination or unfair treatment. **We don't discriminate** based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at <https://www.hhs.gov/ocr/index>.

If you have a disability and need help with access to care, please call us at Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Geisinger Gold Secure Rx (HMO D-SNP), as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 Member non-liability

In the event Geisinger Gold fails to appropriately reimburse a provider for covered services, or in the event that we fail to pay a provider or facility for covered services that have received prior authorization, you shall not be liable for any sums owed by Geisinger Gold.

If you receive services that require prior authorization and your provider has not first obtained prior authorization, except for emergency care/services, urgently needed care, or out-of-area renal dialysis services, neither Geisinger Gold nor Medicare will pay for those services. In addition, if you enter into a private contract with a provider or facility, neither Geisinger Gold nor Medicare will pay for those services.

SECTION 5 Notices

Any notice that we give you will be in writing and delivered either personally, by U.S. Postal Service, or by other delivery service carriers to your last address known to Geisinger Gold.

SECTION 6 Additional notice of subrogation and third-party recovery

Subrogation

If we make any payment to you or on your behalf for covered services, we are entitled to be fully subrogated to any and all rights you have against any person, entity, or insurer that may be responsible for payment of medical expenses and/or benefits related to your injury, illness, or condition. We are entitled to exercise the same rights of subrogation and recovery that are accorded to the Medicare Program under the Medicare Secondary Payer rules.

Once we have made a payment for covered services, we shall have a lien on the proceeds of any judgment, settlement, or other award or recovery you receive, including but not limited to the following:

1. Any award, settlement, benefits, or other amounts paid under any workers' compensation law or award;
2. Any and all payments made directly by or on behalf of a third-party tortfeasor or person, entity, or insurer responsible for indemnifying the third-party tortfeasor;
3. Any arbitration awards, payments, settlements, structured settlements, or other benefits or amounts paid under an uninsured or underinsured motorist coverage policy;
4. Any claims payable under any federal, state, or common law, or
5. Any other payments designated, earmarked, or otherwise intended to be paid to you as compensation, restitution, reimbursement or remuneration for your injury, illness, or condition suffered as a result of the negligence or liability of a third party.

Chapter 11 Legal Notices

You agree to cooperate with us and any of our representatives and to take any actions or steps necessary to secure our lien, including but not limited to:

1. Responding to requests for information about any accidents or injuries within five (5) business days, either personally or through your representative;
2. Responding to our requests, made by ourselves or any representative or affiliate, for information and providing any relevant information that we have requested within five (5) business days, either personally or through your representative; and
3. Participating in all phases of any legal action we commence in order to protect our rights, including but not limited to participating in investigation, discovery, attending depositions, and appearing and testifying at trial

In addition, you agree not to do anything to prejudice our rights, including but not limited to assigning any rights or causes of action that you may have against any person or entity relating to an injury, illness, or condition without our prior express written consent. Your failure to cooperate shall be deemed a breach of your obligations, resulting in potential legal action against you in order for us to protect our rights.

Reimbursement

We are also entitled to be fully reimbursed for any and all benefit payments we make to you or on your behalf that are the responsibility of any person, organization, or insurer. Our right of reimbursement is separate and apart from our subrogation right, and is limited only by the amount of actual benefits paid under our plan. You must immediately pay to us any amounts you recover by judgment, settlement, award, recovery, or otherwise from any liable third party, his or her insurer, and any first party insurer such as Uninsured or Underinsured Motorists Coverage to the extent that we paid out or provided benefits for your injury, illness, or condition during your enrollment in our plan. We are entitled to full reimbursement even if you have not been made whole, are not fully compensated, or only partially recover from your claim.

Antisubrogation rules do not apply

Our subrogation and reimbursement rights shall have first priority, and must be paid prior to payment of any additional claims. Our subrogation right takes priority over any other claimants, your claims or any other person or entity with a claim, right or lien on the recovery. Our subrogation and reimbursement rights will not be affected, reduced, or eliminated by the "made whole" doctrine, the Collateral Source Rule or any other equitable doctrine.

We are not obligated to pursue subrogation or reimbursement either for our own benefit or on your behalf. Our rights under Medicare law and this Evidence of Coverage shall not be affected, reduced, or eliminated by our failure to intervene in any legal action you commence relating to your injury, illness, or condition.

CHAPTER 12:

Definitions of important words

Chapter 12 Definitions of important words

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Annual Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

Area Agency on Aging - Pennsylvania’s Area Agencies on Aging are non-profit organizations funded by Federal, State, and County governments to assist older adults by promoting the ability to live with independence and dignity.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan’s allowed cost-sharing amount. As a member of Geisinger Gold Secure Rx (HMO D-SNP), you only have to pay our plan’s cost-sharing amounts when you get services covered by our plan. We do not allow providers to “balance bill” or otherwise charge you more than the amount of cost sharing your plan says you must pay.

Benefit Period – (Skilled Nursing Facility) The way that both our plan and Original Medicare measures your use of skilled nursing facility (SNF) services. A SNF benefit period begins the day you go into a skilled nursing facility. Up to 100 days are covered per benefit period. Our plan does not require a prior hospital stay. The benefit period ends when you have not received any inpatient hospital care or skilled care in a SNF for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent \$7,400 in covered drugs during the covered year.

Center of Excellence (COE) – A Center of Excellence is a group of licensed physicians who share a hospital or medical center in order to provide high quality specialty healthcare for chronic conditions.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare.

Chapter 12 Definitions of important words

Coinsurance— An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services or prescription drugs. Your Pennsylvania Medical Assistance (Medicaid) benefits will cover your Medicare Part A and Part B coinsurance as long as you follow the plans' rules for getting your care and meet the coverage requirements for Medicare cost sharing assistance under Pennsylvania Medical Assistance (Medicaid).

Community HealthChoices (CHC) – Pennsylvania's mandatory managed care program for individuals who are eligible for both Pennsylvania Medical Assistance (Medicaid) and Medicare (dual eligible), older adults, and individuals with physical disabilities.

Complaint — The formal name for “making a complaint” is “filing a grievance.” The complaint process is used *only* for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or “copay”) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount (for example \$10), rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services or drugs are received. Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed “copayment” amount that a plan requires when a specific service or drug is received; or (3) any “coinsurance” amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service or drug is received.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called “coverage decisions” in this document.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Covered Services – The term we use to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible

Chapter 12 Definitions of important words

for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care, provided by people who do not have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Daily cost-sharing rate – A “daily cost-sharing rate” may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is \$30, and a one-month's supply in your plan is 30 days, then your “daily cost-sharing rate” is \$1 per day.

Deductible – The amount you must pay for health care or prescriptions before our plan pays.

Disenroll or Disenrollment – The process of ending your membership in our plan.

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll individuals who are entitled to both Medicare (title XVIII of the Social Security Act) and medical assistance from a state plan under Pennsylvania Medical Assistance (Medicaid) (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

Dual Eligible Individual – A person who qualifies for Medicare and (Pennsylvania Medical Assistance (Medicaid) coverage.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: (1) provided by a provider qualified to furnish emergency services; and (2) needed to treat, evaluate, or stabilize an emergency medical condition.

Chapter 12 Definitions of important words

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage decision that, if approved, allows you to get a drug that is not on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if our plan requires you to try another drug before receiving the drug you are requesting, or if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Extra Help – A Medicare or a State program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a “generic” drug works the same as a brand name drug and usually costs less.

Grievance – A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This does not involve coverage or payment disputes.

Home Health Aide – A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Home Health Agency Care – Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered Services are listed in the Benefits Chart in Chapter 4 under the heading “Home Health Agency Care.” If you need Home Health Agency Care services, our Plan will cover these services for you provided the Medicare coverage requirements are met. Home Health Agency Care can include services from a home health aide if the services are part of the home health plan of care for your illness or injury. They aren’t covered unless you are also getting a covered skilled service. Home health services don’t include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”

Chapter 12 Definitions of important words

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage before your out-of-pocket costs for the year have reached \$4,660.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

List of Covered Drugs (Formulary or "Drug List") – A list of prescription drugs covered by the plan.

Low Income Subsidy (LIS) – See "Extra Help."

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for covered Part A and Part B services. Amounts you pay for your Medicare Part A and Part B premiums, and prescription drugs do not count toward the maximum out-of-pocket amount. If you are eligible for Medicare cost-sharing assistance under Pennsylvania Medical Assistance (Medicaid), you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. (**Note:** Because our members also get assistance from Pennsylvania Medical Assistance (Medicaid), very few members ever reach this out-of-pocket maximum.)

Medicaid (or Pennsylvania Medical Assistance) – A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Chapter 12 Definitions of important words

Medicare Advantage Open Enrollment Period – The time period from January 1 until March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after an individual is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be a 1) HMO, 2) PPO, a 3) Private Fee-for-Service (PFFS) plan, or a 4) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP) In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D members who have reached the Coverage Gap Stage and who are not already receiving “Extra Help.” Discounts are based on agreements between the Federal government and certain drug manufacturers.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

“Medigap” (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill “gaps” in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or “Plan Member”) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Chapter 12 Definitions of important words

Network Pharmacy – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – “Provider” is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. “**Network providers**” have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called “plan providers.”

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called “coverage decisions” in this document.

Original Medicare (“Traditional Medicare” or “Fee-for-service” Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Orphan Drug – A drug or biological product that treats a rare condition or disease. In the United States, the FDA orphan drug designation is given to drugs that are intended to treat, diagnose or prevent rare diseases or conditions that affect fewer than 200,000 people or that will cost more to develop and produce than is expected to be made from sales of the drug. It is generally easier for a drug company to obtain approval from the FDA for an Orphan drug. Orphan drugs are usually very expensive and used only when there are no other effective treatment alternatives available.

Out-of-Network Pharmacy – A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that does not have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan.

Out-of-Pocket Costs – See the definition for “cost sharing” above. A member’s cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member’s “out-of-pocket” cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan. (*In*

Chapter 12 Definitions of important words

Pennsylvania, this program is sometimes called the Living Independence for the Elderly (LIFE) Program.)

Part C – see “Medicare Advantage (MA) Plan.”

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded from Part D coverage by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan. If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for

Primary Care Provider (PCP) –The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization - Approval in advance to get services or certain drugs. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary.

Prosthetics and Orthotics –Medical devices including, but not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it’s also generally the area where you can get

Chapter 12 Definitions of important words

routine (non-emergency) services. The plan must disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting “Extra Help” with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Pennsylvania Medical Assistance (Medicaid), who reside in a nursing home, or who have certain chronic medical conditions.

Special Supplemental Benefits for the Chronically Ill (SSBCI) - SSBCI are benefits that can be offered to Medicare Advantage members with one or more complex chronic conditions, who are at high risk for hospitalization or adverse health outcomes, and who require intensive care coordination.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Benefit - A supplemental benefit is an item or service covered by a Medicare Advantage Plan that is not covered by Original Medicare. These benefits do not need to be provided by Medicare providers or at Medicare-certified facilities. Instead, to receive these items or services, you need to follow your plan's rules.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Services – Covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

Value Based Insurance Design (VBID) - MA health plan innovations designed to reduce Medicare program expenditures, enhance the quality of care for Medicare beneficiaries, including those with low incomes such as dual-eligibles, and improve the coordination and efficiency of health care service delivery.

Geisinger Gold Secure Rx (HMO D-SNP) Member Services

Method	Member Services – Contact Information
CALL	<p>1-800-498-9731 or Pharmacy Member Services 1-800-988-4861 Calls to this number are free. Our business hours: October 1- March 31: 8 a.m. to 8 p.m. 7 days a week April 1- September 30: 8 a.m. to 8 p.m. Monday-Friday; 8 a.m. to 2 p.m. Saturday</p> <p>After hours, an automated voice messaging service is available. If you leave a message, please include your name, phone number and the time you called. A Customer Service Representative will return your call within one business day. Member Services also has free language interpreter services available for non-English speakers.</p>
TTY	<p>TTY users call PA Relay: 711 or 1-800-654-5984 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Our business hours: October 1- March 31: 8 a.m. to 8 p.m. 7 days a week April 1- September 30: 8 a.m. to 8 p.m. Monday-Friday; 8 a.m. to 2 p.m. Saturday</p>
FAX	1-570-271-5871
WRITE	<p>Geisinger Gold 100 North Academy Avenue Danville, PA 17822-2580</p>
WEBSITE	www.GeisingerGold.com

Pennsylvania Medicare Education and Decision Insight (PA MEDI)

Pennsylvania Medicare Education and Decision Insight (PA MEDI) is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Pennsylvania Medicare Education and Decision Insight (PA MEDI) (SHIP) - Contact Information
CALL	1-800-783-7067
WRITE	<p>Pennsylvania Medicare Education and Decision Insight (PA MEDI) Pennsylvania Department of Aging 555 Walnut Street 5th Floor Harrisburg, PA 17101-1919</p>
WEBSITE	www.aging.pa.gov/aging-services/medicare-counseling/Pages/default.aspx

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