

# Operations Bulletin

Date: February 13, 2014  
To: Participating Providers  
Subject: Geisinger Gold 2014



## Geisinger Gold's 2014 products.

Begun in 1994, Geisinger Gold serves more than 73,000 members. Geisinger Gold has held the highest accreditation level from the National Committee for Quality Assurance (NCQA) since 2006. Geisinger Gold 2014 continues to offer a variety of Medicare Advantage plans designed to meet the unique needs and budgets of Medicare beneficiaries throughout Pennsylvania.

### Plans offered in Pennsylvania for 2014:

<b>Classic 1</b> (HMO)	<b>Preferred 1</b> (PPO)
<b>Classic 3</b> (HMO)	<b>Preferred 2</b> (PPO)
<b>Classic 4</b> (HMO)	<b>Preferred 3</b> (PPO)
<b>Classic Plus</b> (HMO POS)*	<b>Preferred Custom</b> (PPO)
<b>Classic Custom</b> (HMO)	<b>Secure 1</b> (HMO SNP - Dual Eligible)
<b>Reserve</b> (MSA)	<b>Classic REHP</b> (HMO - PEBTF)


The Member cost-sharing grids in this Bulletin include more details on our 2014 plans. Additional information about Geisinger Gold, including tools to verify benefits and Member eligibility can be found on the Geisinger Health Plan page on NaviNet or in the Provider Service Center at [thehealthplan.com](http://thehealthplan.com).

If you have any questions about Geisinger Gold, or would like additional reference materials for your office or patients, please contact the **Gold Customer Service Team at (800) 498-9731**, or your Provider Relations Representative at (800) 876-5357.

### 2014 Plan Highlights

- Classic 1 HMO Plan is covering Preferred Brand (One Touch) Diabetic Testing Supplies at no cost to members with diabetes.
- The Secure 3 Chronic Care Special Needs Plan for members with diabetes and heart failure has been discontinued for 2014.
- Medicare has changed how often Plans may cover Preventive Cervical Cancer Screening (Pap and Pelvic Exam). For more information, see the "Things You Should Know" section on page 11.

### Geisinger Gold Member Identification Cards

	
<b>CLASSIC 1</b> <b>\$0 Deductible Rx (HMO)</b> <b>A Medicare Advantage Plan</b>	
First Name Last Name ID #: 12345678901 Medical Record #: 12345678	CMS: HXXXX-XXX Issuer: 80840 RxBin: 015574 RxPCN: ASPROD1 Rx Grp: GHS06
Primary Care: XXXX XXXXXXXXXXXXXXXXX Office #: 123/456-7891 Tel-A-Nurse #: 877-543-5061	PCP Copay \$XX Spec Copay \$XX ER Copay \$XX
 www.GeisingerGold.com	

<b>Geisinger Gold Customer Service: 1-800-498-9731</b> or 570-271-8771. TDD/TTY Hearing Impaired, contact PA Relay at: 711 Call if you have coverage questions and as soon as possible upon hospitalization or after an emergency. Emergencies: Call 911 or your local emergency service.	
To access Mental Health and Substance Abuse services, call 1-888-839-7972. Members with prescription benefit questions call 1-800-988-4861 or 570-271-5673.	
Mail Medical Claims to: <b>Geisinger Health Plan</b> P.O. Box 8200 Danville, PA 17821-8200	General Information: <b>Geisinger Health Plan</b> 100 N. Academy Avenue Danville, PA 17822-3229
XX-XX	Benefit Code: ABCDEFGHIJ Issue Date: issuerdate
Pharmacists call 1-877-391-1123 for pharmacy benefit information.	
Mail Dental Claims to: Delta Dental, P.O. Box 2105, Mechanicsburg, PA 17055-6999 For Dental benefit inquiries call 1-800-498-9731.	

The front of Gold Member Identification Cards will display the Member's PCP, SCP, and ER copays, pharmacy benefit information, as well as a 'No Referrals Required' notice if applicable

**Classic 1 (HMO) - *Must use a Participating Provider***

Covers routine office visits, immunizations, diagnostic tests and x-rays. In addition to Medicare-covered services, the plan also provides coverage towards routine eyeglasses, hearing aid and preventive dental benefits, SilverSneakers fitness center coverage, \$0 Annual Wellness Visits, Medicare preventive services at \$0 copay, worldwide emergency room coverage, and nationally accredited Health and Wellness programs. This plan also features an out-of-pocket maximum of \$2,800 (premiums do not apply towards the annual maximum).

**Classic Plus (HMO POS) - *Point-of-Service Feature allows for out-of-network services***

An HMO plan with a Point-of-Service (POS) feature that allows the flexibility of obtaining covered services in-network, or for an additional cost, out-of-network. In addition to Medicare-covered services, Classic Plus also includes coverage toward eyeglasses, hearing aid and preventive dental benefits, SilverSneakers fitness membership, worldwide emergency room coverage, and nationally accredited Health and Wellness programs. Like our other HMO plans, Classic Plus Members choose a Primary Care Provider who will provide most routine care and who will help arrange or coordinate specialty care. Members may choose to see any provider who is eligible to participate in Medicare, however, the Member's share of the cost will usually be more for covered services obtained out-of-network than for services obtained in-network. The plan has an annual out-of-pocket maximum of \$4,300 for in-network services. There is no out-of-pocket maximum for services obtained out-of-network.

**Classic 3 (HMO) - *Must use a Participating Provider***

A plan with a \$0 plan premium (for Part C medical benefits) and \$0 Medicare preventive services, including an annual wellness visit. Copays apply for services such as Primary Care and Specialist doctor visits, rehab, ER and partial hospitalization. In addition to Medicare covered services, the plan also provides coverage toward routine eyeglasses, hearing aids, and preventive dental benefits. Includes Silver Sneakers fitness membership and worldwide emergency room coverage. For other covered services, Members pay a \$1,300 deductible, which counts toward a \$2,250 out-of-pocket maximum. Once the out-of-pocket maximum is met, Medicare-covered services are covered in full.

**Classic 4 (HMO) - *Must use a Participating Provider***

Available only in Carbon, Lehigh, and Northampton counties. Benefits are identical to Classic 3 (above). Members pay a \$1,600 deductible, which counts toward a \$2,250 out-of-pocket maximum. Once the out-of-pocket maximum is met, Medicare-covered services are covered in full.

**Classic PEBTF REHP (HMO) - *Must use a Participating Provider***

Available to eligible Commonwealth of Pennsylvania retirees. Zero cost-sharing for most inpatient and outpatient services. Small copays apply to Primary Care and Specialist doctor visits, rehab, and mental health services. In general, Member pays 100% for preventive dental services and routine hearing exams/hearing aids. Part D prescription drug coverage is facilitated through a separate Pennsylvania Employees Benefit Trust Fund REHP Prescription Drug plan provided by a different insurance carrier.

**Classic Custom (HMO) - *An HMO Plan with Customized Benefits for Employer Groups***

Geisinger Gold Classic Custom (HMO) is an Employer or Union Group HMO Medicare Advantage Plan with customized benefits. Based on Gold Classic 1 or Classic 3 plans, the employer group may design a group plan with customized cost sharing and/or supplemental benefits.

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- Premiums do not apply towards the annual out-of-pocket maximum.
  - All plans require Members to continue to pay their monthly Medicare Part B premium, and live in the service area.
  - Medicare beneficiaries with ESRD are generally not eligible to join Medicare Advantage Plans unless they were a plan Member prior to developing ESRD. More information is available at [www.Medicare.gov](http://www.Medicare.gov)
  - Refer to Provider Service Center at [www.thehealthplan.com](http://www.thehealthplan.com) to verify benefits and cost-sharing.

### **Preferred 1 (PPO)**

No Primary Care Provider selection or referrals for specialists (in or out-of-network) are required with this plan. After a \$195 deductible (in and out-of-network combined) is met, this plan has an in-network **\$440 inpatient copay per hospital stay**, fixed **\$7/\$25 copays for in-network PCP/Specialist visits**; \$20/\$35 out-of-network PCP/Specialist visits. Most other benefits covered at 20% after deductible has been met. Includes coverage towards eyeglasses, hearing aid and preventive dental benefits, Silver Sneakers fitness center coverage, \$0 Medicare preventive services, \$0 annual wellness visits, worldwide emergency room coverage, and nationally accredited Health and Wellness programs. Annual in-network out-of-pocket maximum is \$3,400. Combined in and out-of-network out-of-pocket maximum is \$5,100.

### **Preferred 2 (PPO)**

No Primary Care Provider selection or referrals for specialists (in or out-of-network) are required with this plan. Similar to Preferred 1, with lower premium and higher cost sharing for Member. \$100 annual plan deductible (in-and-out-of-network combined) applies to most plan benefits. Annual in-network out-of-pocket maximum is **\$3,900**. Combined in and out-of-network out-of-pocket maximum is **\$5,600**.

### **Preferred 3(PPO)**

No Primary Care Provider selection or referrals for specialists (in or out-of-network) are required with this plan. Available only in Carbon, Lehigh, and Northampton counties. Features a \$120 deductible (in and out-of-network combined). Most benefits are similar to Preferred 1 (above). Out-of-pocket maximums are the same as Preferred 1.

### **Preferred Custom (PPO) - A PPO Plan with Customized Benefits for Employer Groups**

Geisinger Gold Preferred Custom (PPO) is an Employer or Union Group PPO Medicare Advantage Plan with customized benefits. Based on Geisinger Gold's Preferred 1 or Preferred 2 plans, the employer group may design a group plan with customized cost sharing and/or supplemental benefits.

### **Secure 1 (HMO SNP) - Special Needs Plan for Dual Eligibles with Medicare and Medicaid**

Designed for people who are enrolled in Medicare and also have Full Medical Medicaid coverage. Secure 1 offers all the same coverage as traditional Medicare, plus extra benefits including Silver Sneakers fitness center coverage, worldwide emergency services, dental benefits up to \$2,000 per year (which include cleanings, simple fillings, simple extractions, **and dentures**), and coverage for over-the-counter medications and medical supplies (**up to \$65 per calendar quarter**). Secure 1 also includes Part D prescription drug coverage and Medicare preventive services. Members do not pay cost sharing. Medicaid is the secondary payer, and all cost sharing should be billed to Medicaid. Providers do not need to be a participating provider with Medicaid to accept this product, however, any balance remaining after Geisinger Gold's payment is not the liability of the Member. Providers may bill Medicaid as the secondary payer. Members may not be balanced billed for any amount. Eligible beneficiaries can join Secure 1 any time of the year.

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- *Premiums do not apply towards the annual out-of-pocket maximum.*
  - *All plans require Members to continue to pay their monthly Medicare Part B premium, and live in the service area.*
  - *Medicare beneficiaries with ESRD are generally not eligible to join Medicare Advantage Plans unless they were a plan Member prior to developing ESRD. More information is available at [www.Medicare.gov](http://www.Medicare.gov).*
  - *Refer to Provider Service Center at [www.thehealthplan.com](http://www.thehealthplan.com) to verify benefits and cost-sharing.*

## Reserve (MSA)

A Medicare Advantage Plan that combines a high-deductible health plan with a personal medical savings account. The plan deposits \$1,500 from Medicare into the Member's MSA Plan savings account at the beginning of each year. The Reserve (MSA) Plan has an annual deductible of \$3,000, but no monthly premium. Members can go to any doctor or hospital that accepts Medicare. No referrals are necessary. Providers should bill Geisinger Gold. Once the annual deductible is met, the plan pays for Medicare-covered medical expenses in full. *(Please note: Medicare does not allow MSA plans to provide first-dollar coverage for any benefit. All covered benefits are subject to the \$3,000 annual deductible.)* Members may use funds from their MSA account to pay for any IRS qualified medical expense, but only expenses incurred for Medicare-covered services count toward the annual deductible. Any money remaining in the MSA bank account at the end of the year will roll over for use toward qualified medical expenses next year. This plan does not include prescription drug coverage. Members may join a separate Medicare Part D Prescription Drug plan from the carrier of their choosing for additional cost.

## GEISINGER GOLD MEDICARE PART D PRESCRIPTION DRUG COVERAGE

All plans except Reserve (MSA) and Secure 1 (HMO SNP) are available with optional \$0 Deductible prescription drug coverage. This benefit includes no deductible and fixed, predictable copays in the initial coverage level and cost sharing up to the coverage gap. Members will receive coverage through the gap for tier 1 generic drugs at a \$3 copay, 52.5% brand drug and 28% generic drug coverage (for all generics not covered on our tier 1), as well as the Geisinger Gold contracted rates (discount from retail) on prescriptions while in the coverage gap.

### Geisinger Gold 2014 Medicare Part D Cost Sharing

Classic 1 (HMO) with \$0 Deductible Rx Classic Plus (HMO-POS) with \$0 Deductible Rx	Preferred Generic \$3; Non-Preferred Generic \$7; Preferred Brand Drug \$39; Non-Preferred Brand Drug \$69; Specialty Drugs 33%.
Classic 3 (HMO) with \$0 Deductible Rx Classic 4 (HMO) with \$0 Deductible Rx Preferred 1 (PPO) with \$0 Deductible Rx Preferred 2 (PPO) with \$0 Deductible Rx Preferred 3 (PPO) with \$0 Deductible Rx	Preferred Generic \$3; Non-Preferred Generic \$10; Preferred Brand Drug \$39; Non-Preferred Brand Drug \$80; Specialty Drugs 33%.
Secure 1 (HMO-SNP) with Standard Part D Rx <i>Secure 1 Members are Dual Eligible and have Medicare LIS Reduced Cost Sharing. The actual amount of their LIS copayment for Part D drugs is determined by their level of subsidy.</i>	Preferred Generic 25%; Non-Preferred Generic 25%; Preferred Brand Drug 25%; Non-Preferred Brand Drug 25%; Specialty Drugs 25%.
Geisinger Gold PSERS HOP (PPO) <i>(Pennsylvania School Employee's Retirement System, Health Options Program)</i>	Preferred Generic \$3; Non-Preferred Generic \$10; Preferred Brand Drug \$35; Non-Preferred Brand Drug \$65; Specialty Drugs 33%.

Other Employer Group Medicare Advantage Plans may have customized prescription drug cost sharing unique to their group's plan.

After yearly out-of-pocket drug costs reach \$4,550, a member pays \$2.55 copay for generic (including brand drugs treated as generic) and \$6.35 copay for all other drugs or 5% coinsurance, whichever amount is greater.

Reserve (MSA) does not include Part D Prescription Drug Coverage. MSA Members may join a separate Medicare Part D Prescription Drug plan from the carrier of their choosing.

# Classic HMO - 2014

PCP selection, referrals for specialty care, and use of network providers required

	Classic 1	Classic 3/Classic 4
<b>General Provisions</b>		
Annual Plan Deductible	\$0	\$1,300/\$1,600
OOP Maximum (a)	\$2,800	\$2,250
<b>Hospital Inpatient</b>		
Acute Care	\$100/day (days 1-5) \$0/day (days 6-90)	Deductible up to \$790 Max*/ Deductible up to \$750 Max*
Mental Health	\$100/day (days 1-5)	Deductible up to \$790 Max*/ Deductible up to \$750 Max*
<b>SNF</b>	\$50/day (days 1-20) \$75/day (days 21-44) \$0/day (days 45-100)	Deductible up to \$1,000 Max*
<b>Home Health Care</b>	\$0	\$0
<b>Outpatient</b>		
Emergency Room (worldwide)	\$65 (d)	\$65 (d)
Ambulatory Surgical Center	\$250	\$0 after annual deductible is met
Outpatient Hospital Surgery	\$250	\$0 after annual deductible is met
Radiology - General (X-rays)	\$25	\$0 after annual deductible is met
Radiology - MRI/CAT/PET	\$100	\$0 after annual deductible is met
Therapeutic Radiology	\$60	\$0 after annual deductible is met
Laboratory Tests	\$5	\$0 after annual deductible is met
Physical, Occupational, or Speech Therapy	\$10	\$25
<b>Physician</b>		
PCP Visits	\$10	\$10
Annual Routine Physical Exam	\$10	\$10
Specialist Visits	\$20	\$25
Urgent Care (Copay waived if admitted)	\$20 (d)	\$25 (d)
Chiropractor	\$20	\$20
Podiatrist	\$20	\$25
Psych Services (Ind/Grp)	\$25/\$10	\$25/\$10
Substance Abuse (Ind/Grp)	\$25/\$10	\$25/\$10
<b>Other</b>		
Medicare Part B Covered Drugs	20%	20%
Ambulance (Waived if admitted)	\$100	\$0 after annual deductible is met
Diabetic Testing Supplies (b)	\$0 for Preferred Brand Supplies	20%
DME and DME-related Supplies	20%	20% after deductible
Prosthetics and Prosthetic-related Supplies	20%	20% after deductible
Medicare Part B Covered Immunizations (Flu, Pneumonia, Hep B)	\$0	\$0
Vision Exams (medical/routine)	\$20/\$20; 1/year	\$25/\$25; 1/year
Routine Eyewear (Glasses or Contacts) (c)	\$200 allowance every 2 years	\$200 allowance every 2 years
Hearing Exams (diagnostic/routine)	\$20/\$20; 1/year	\$25/\$25; 1/year
Hearing Aids (c)	\$800 allowance every 3 years	\$800 allowance every 3 years
Medicare Annual Wellness Visit (1/year)	\$0	\$0
Medicare Preventive Services	\$0	\$0
Routine Foot Care (4 times/year)	\$0	\$0
Fitness Center	\$0	\$0
Preventive Dental (c)	\$20 cleanings and exams every 6 months; \$20 - \$30 x-rays once a year	
<b>Part D Rx</b>	No Rx and \$0 deductible Rx plans only	

Notes: (a) Coinsurance and copays apply toward out-of-pocket maximum.

(b) \$0 copay for preferred brand glucometer every 2 years. \$0 copay for preferred brand test strips and any brand lancet devices. 20% copay for non-preferred brand test strips and glucometers. Prior authorization required for non-preferred supplies and/or higher quantities

(c) Does not apply to the plan level OOP Max

(d) Copay waived if admitted to hospital within 3 days of visit

\* Inpatient deductible paid also counts toward annual plan deductible



# Classic PLUS (HMO POS) - 2014

Point-of-Service HMO Plan with the flexibility to see providers in or out-of-network\*

	Classic Plus In-network	Classic Plus Out-of-network
<b>General Provisions</b>		
Annual Plan Deductible	\$0	\$0
Out-of-pocket Maximum (a)	\$4,300	No Maximum Limit
<b>Inpatient</b>		
Acute Care	\$125/day (days 1-5)	20%
Mental Health	\$125/day (days 1-5)	20%
<b>SNF</b>		
	\$25/day (days 1-20)	20%
	\$70/day (days 21-77)	
	\$0/day (days 78-100)	
<b>Home Health Care</b>		
	\$0	20%
<b>Outpatient</b>		
Emergency Room (worldwide) (d)	\$65 (d)	\$65 (d)
Ambulatory Surgical Center	\$275	20%
Outpatient Hospital Surgery	\$275	20%
Radiology - General (X-rays)	\$25	20%
Radiology - MRI/CAT/PET	\$100	20%
Therapeutic Radiology	20%	No coverage
Laboratory Tests	\$5	20%
Physical, Occupational, or Speech Therapy	\$10	20%
<b>Physician</b>		
PCP Visits	\$10	\$15
Annual Routine Physical Exam	\$10	\$15
Specialist Visits	\$25	\$30
Urgent Care (d)	\$25 (d)	\$25 (d)
Physical Therapy	\$10	20%
Chiropractor	\$20	20%
Podiatrist	\$20	20%
Psych Services (Ind/Grp)	\$25/\$10	20%
Substance Abuse (Ind/Grp)	\$25/\$10	20%
<b>Other</b>		
Medicare Part B Covered Drugs	20%	No coverage
Ambulance (Waived if admitted)	\$100	20%
DME/Supplies/Diabetic Monitoring (b)	20%	20%
Prosthetics	20%	20%
Medicare Part B Covered Immunizations	\$0	\$25
Vision Exams (medical/routine)	\$20/\$20; 1/year	20%/ 20% - 1/year
Routine Eyewear (Glasses or Contacts) (c)	\$200 allowance every 2 years	\$200 allowance every 2 years
Hearing Exams (diagnostic/routine)	\$20/\$20; 1/year	20%/ 20% - 1/year
Hearing Aids (c)	\$800 allowance every 3 years	\$800 allowance every 3 years
Annual Wellness Visit (1/year)	\$0	\$25
Medicare Preventive Services	\$0	\$25
Routine Foot Care (4 times/year)	\$0	20%
Fitness Center	\$0	20%
Preventive Dental (c)	\$20 cleanings and exams every 6 months; \$20 - \$30 x-rays once a year	20%
<b>Part D Rx</b>		
	No Rx and \$0 deductible Rx plans only	

Notes: (a) Coinsurance and copays apply toward out-of-pocket maximum.

(b) \$0 copay for preferred brand glucometer every 2 years. Prior authorization required for non-preferred supplies and/or higher quantities

(c) Does not apply to the plan level OOP Max

(d) Copay waived if admitted to hospital within 3 days of visit

\*PCP selection is required. In-network PCP is encouraged but not required; PCP may be out-of-network provider. PCP referrals for specialty care are encouraged, but not required for payment of claim.

# Classic REHP PEBTF HMO - 2014

PCP selection, referrals for specialty care, and use of network providers required

	Classic REHP HMO for Pennsylvania Employees Benefit Trust Fund
<b>General Provisions</b>	
Annual Plan Deductible	\$0
OOP Maximum (a)	\$2,500
<b>Hospital Inpatient</b>	
Acute Care	0% (no limit on number of days)
Mental Health	0% (no limit on number of days)
<b>SNF</b>	\$0/day (days 1-180)
<b>Home Health Care</b>	\$0
<b>Hospital Outpatient</b>	
Emergency Room (worldwide)	\$50 (b)
Ambulatory Surgical Center	\$0
Outpatient Hospital Surgery	\$0
Radiology - General (X-rays)	\$0
Radiology - MRI/CAT/PET	\$0
Therapeutic Radiology	\$0
Laboratory Tests	\$0
Physical, Occupational, or Speech Therapy	\$10
<b>Physician</b>	
PCP Visits	\$15
Annual Routine Physical Exam	\$15
Specialist Visits	\$15
Urgent Care	\$50 (b)
Physical Therapy	\$10
Chiropractor	\$15
Podiatrist	\$15
Psych Services (Ind/Grp)	\$15
Substance Abuse (Ind/Grp)	\$0
<b>Other</b>	
Medicare Part B Covered Drugs	\$0
Ambulance (Waived if admitted)	\$0
DME/Supplies/Diabetic Monitoring	\$0
Prosthetics	\$0
Medicare Part B Covered Immunizations	\$0
Vision Exams (medical/routine)	\$0 Medicare-covered vision exams. Routine exams not covered.
Routine Eyewear (Glasses or Contacts) (c)	Not Covered
Hearing Exams (diagnostic/routine)	\$0 Medicare-covered hearing exams. Routine exams are not covered.
Hearing Aids	Not Covered
Annual Wellness Visit (1/year)	\$0
Medicare Preventive Services	\$0
Routine Foot Care (4 times/year)	Not Covered
Fitness Center	\$0
Preventive Dental	Not Covered
<b>Part D Rx</b>	Part D prescription drug coverage is facilitated through the Pennsylvania Employees Benefit Trust Fund REHP Prescription Drug plan

Notes: (a) Coinsurance and copays apply toward out-of-pocket maximum.  
 (b) Copay waived if admitted to hospital within 3 days of visit

# Reserve MSA - 2014

No PCP selection, referrals for specialty care, or use of network providers required

	Reserve
<b>General Provisions</b>	
Annual Plan Deductible	\$3,000
Fund Contribution	\$1,500
OOP Maximum (a)	\$3,000
<b>Hospital Inpatient</b>	
Acute Care	\$0 after annual deductible is met
Mental Health	\$0 after annual deductible is met
<b>SNF</b>	\$0 after annual deductible is met
<b>Home Health Care</b>	\$0 after annual deductible is met
<b>Hospital Outpatient</b>	
Emergency Room (worldwide)	\$0 after annual deductible is met
Ambulatory Surgical Center	\$0 after annual deductible is met
Outpatient Hospital Surgery	\$0 after annual deductible is met
Radiology - General (X-rays)	\$0 after annual deductible is met
Radiology - MRI/CAT/PET	\$0 after annual deductible is met
Therapeutic Radiology	\$0 after annual deductible is met
Laboratory Tests	\$0 after annual deductible is met
Physical, Occupational, or Speech Therapy	\$0 after annual deductible is met
<b>Physician</b>	
PCP Visits	\$0 after annual deductible is met
Specialist Visits	\$0 after annual deductible is met
Urgent Care	\$0 after annual deductible is met
Physical Therapy	\$0 after annual deductible is met
Chiropractor	\$0 after annual deductible is met
Podiatrist	\$0 after annual deductible is met
Psych Services (Ind/Grp)	\$0 after annual deductible is met
Substance Abuse (Ind/Grp)	\$0 after annual deductible is met
<b>Other</b>	
Medicare Part B Covered Drugs	\$0 after annual deductible is met
Ambulance (Waived if admitted)	\$0 after annual deductible is met
DME/Supplies/Diabetic Monitoring (b)	\$0 after annual deductible is met
Prosthetics	\$0 after annual deductible is met
Medicare Part B Covered Immunizations	\$0 after annual deductible is met
Vision Exams (medical/routine)	\$0 after annual deductible is met for Medicare-covered vision exams. Routine exams are not covered.
Post-Cataract Surgery Eyeglasses or Contacts	\$0 after annual deductible is met for Medicare-covered eyewear. Routine Eyewear Not Covered
Hearing Exams (diagnostic)	\$0 after annual deductible is met for Medicare-covered hearing exams. Routine exams are not covered
Hearing Aids	Not Covered
Annual Wellness Visit (1/year)	\$0 after annual deductible is met (Routine Physical Exams are not covered)
Medicare Preventive Services	\$0 after annual deductible is met
Routine Foot Care (4 times/year)	Not Covered
Fitness Center	Not Covered
Preventive Dental	Not Covered
<b>Part D Rx</b>	N/A

Notes: (a) Deductible, coinsurance and copays apply toward out-of-pocket maximum.

(b) Original Medicare limits apply

**Medicare participation is required to treat and accept reimbursement for Reserve MSA Members. Reimbursement will equal Medicare current rates for Medicare Part A and Medicare Part B covered services. Medicare does not allow plan coverage of any benefit until deductible has been met, including preventive services. Members are liable for the cost of services not covered by Medicare; payment for these services will not count towards the Member's deductible. Members may not be balanced billed; any balance after Geisinger GOLD payment is not the liability of the Member.**



# Preferred PPO - 2014

No PCP selection, referrals for specialty care, or use of network providers required

	Preferred 1/Preferred 3		Preferred 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>General Provisions</b>	<i>*Benefits marked with Asterisk are subject to annual plan deductible</i>			
Annual Plan Deductible (b)	\$195 <b>Preferred 1</b> Combined Deductible \$120 <b>Preferred 2</b> Combined Deductible		\$100 Combined Deductible	
OOP Maximum (a)	\$3,400	\$5,100 (b)	\$3,900	\$5,600 (b)
<b>Hospital Inpatient</b>				
Acute Care	Preferred 1 Preferred 3	*\$440/admission *20%	*\$225/day (days 1-5)	*25%
Mental Health	Preferred 1 Preferred 3	*\$440/admission *20%	*\$225/day (days 1-5)	*25%
<b>SNF</b>		*\$50/day (days 1-20) \$152/day (days 21-35) \$0/day (days 36-100)	\$25/day (days 1-20) \$152 /day (days 21-43) \$0/day (days 44-100)	*25%
<b>Home Health Care</b>		\$0	\$0	*25%
<b>Outpatient</b>				
Emergency Room (worldwide)	\$65 (d)		\$65 (d)	
Ambulatory Surgical Center	Preferred 1 Preferred 3	*\$250 *20%	*\$375	*25%
Outpatient Hospital Surgery	Preferred 1 Preferred 3	*\$250 *20%	*\$375	*25%
Radiology - General (X-rays)		*\$45	*\$45	*25%
Radiology - MRI/CAT/PET		*\$125	*20%	*25%
Therapeutic Radiology		*\$45	*20%	*25%
Laboratory Tests		*\$10	*\$15	*25%
Physical, Occupational, Speech Therapy		\$25	*\$35	*25%
<b>Physician</b>				
PCP Visits		\$7	*\$20	*\$30
Annual Routine Physical Exam		\$7	\$20	*\$30
Specialist Visits		\$25	*\$35	*\$45
Urgent Care	\$25 (d)		\$35 (d)	
Chiropractor		*\$20	*\$35	*\$45
Podiatrist		\$25	*\$35	*\$45
Psych Services (Ind/Grp)		\$25/\$10	*\$25/*\$10	*25%
Substance Abuse (Ind/Grp)		\$25/\$10	*\$25/*\$10	*25%
<b>Other</b>				
Medicare Part B Covered Drugs		*20%	20%	*25%
Ambulance (Waived if admitted)		*\$150	*\$150	*25%
DME/Supplies/Diabetic Monitoring (e)		*20%	*20%	*25%
Prosthetics		*20%	*20%	*25%
Medicare Part B Covered Immunizations		\$0	\$0	\$45
Vision Exams (medical/routine)		\$25/\$25 1/yr	*\$35/*\$35 1/yr	*\$45/*\$45 1/yr
Routine Eyewear (glasses or contacts) (c)		\$200 allowance every 2 years	\$200 allowance every 2 years	
Hearing Exams (diagnostic/routine)		\$25/\$25 1/yr	*\$35/*\$35 1/yr	*\$45/*\$45 1/yr
Hearing Aids (c)		\$800 allowance every 3 years	\$800 allowance every 3 years	
Annual Wellness Visit (1/year)		\$0	\$35	\$45
Medicare Preventive Services		\$0	\$35	\$45
Routine Foot Care (4 times/year)		\$0	*\$35	*\$45
Fitness Center		\$0	20%	25%
Preventive Dental- Cleaning/Exams every 6 months, x-rays once a year. (c)		\$20 Cleaning/Exam \$20 - \$30 x-rays	\$20 Cleaning/Exam \$20 - \$30 x-rays	25%

**Part D Rx** Plans available with \$0 Deductible Rx benefit or with No Rx benefit

Notes: (a) Deductible, coinsurance, copays apply to out-of-pocket max (d) Copay waived if admitted to hospital within 3 days  
 (b) Combined in- and out-of-network (e) Prior Auth required for non-preferred brand or higher quantity  
 (c) Does not apply to the plan level OOP Max

**\*Annual Plan Deductible must be met before coverage begins.**

# Secure SNP - 2014

PCP selection, referrals for specialty care, and network providers required

	Secure 1 - Dual-Eligible SNP (a)
<b>General Provisions</b>	
Deductible	\$0
OOP Maximum (b)	\$6,700
<b>Hospital Inpatient</b>	
Acute Care	\$0
Mental Health	\$0
<b>SNF</b>	\$0
<b>Home Health Care</b>	\$0
<b>Outpatient</b>	
Emergency Room (worldwide)	\$0
Ambulatory Surgical Center	\$0
Outpatient Hospital Surgery	\$0
Radiology - General (X-rays)	\$0
Radiology - MRI/CAT/PET	\$0
Therapeutic Radiology	\$0
Laboratory Tests	\$0
Physical, Occupational, or Speech Therapy	\$0
<b>Physician</b>	
PCP Visits	\$0
Annual Routine Physical Exam	\$0
Specialist Visits	\$0
Urgent Care	\$0
Chiropractor	\$0
Podiatrist	\$0
Psych Services (Ind/Grp)	\$0
Substance Abuse (Ind/Grp)	\$0
<b>Other</b>	
Medicare Part B Covered Drugs	\$0
Ambulance (Waived if admitted)	\$0
DME	\$0
Prosthetics	\$0
Diabetic Monitoring Supplies (c)	\$0 preferred glucometer every 2 years. 20% all other supplies.
Medicare Part B Covered Immunizations	\$0
Vision Exams (medical/routine)	\$0
Routine Vision Hardware (d)	\$275 allowance each year
Hearing Exams (diagnostic/routine)	\$0
Hearing Aids (d)	\$1,300 allowance every 3 years
Annual Wellness Visit (1/year)	\$0
Medicare Preventive Services	\$0
Routine Foot Care (4 times/year)	\$0
Fitness Center	\$0
OTC Drug Benefit (f) (d)	\$65 allowance every 3 months
Preventive Dental (d)	\$0 exams every 6 months; \$2,000/year max includes cleanings every 6 months, dental X rays, simple fillings, simple extractions and dentures.
<b>Part D Rx</b>	Part D Standard defined benefit

Notes: (a) \$0 cost sharing to the Member. Bill cost sharing to PA Medical Assistance. (d) Does not apply to the plan level OOP Max  
 (b) Coinsurance and copays apply to out-of-pocket maximum (e) Copay waived if admitted to hospital within 3 days  
 (c) Prior authorization required for non-preferred brand supplies and/or higher quantities (f) Script required; Drug must be in OTC Point-of-Sale Pharmacy Claims system to be covered.

**Providers may bill Medicaid as a secondary payer. Provider Medicaid participation not required to treat and accept GHP reimbursement. Members may not be balanced billed; any balance after Geisinger GOLD payment is not the liability of the Member.**

# Things you should know for 2014

## **A Reminder - Medicare Advantage Plans may only cover the same Preventive Services at the same frequency as Original Fee-for-Service Medicare.**

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CPT codes designated by Medicare as \$0 Preventive Screening Services are covered by Geisinger Gold with no cost to the member. For our members to utilize the \$0 cost sharing benefit for Medicare-covered preventive services, the claim must be billed with the Medicare-designated \$0 Preventive Service CPT and ICD-9 codes.

As of January 1, 2014, **the frequency of coverage for Medicare-covered Preventive Cervical Cancer Screening is changing.** For women at normal risk, Cervical Cancer Screening (Screening Pelvic Exam and Screening Pap Test) is covered once every two (2) calendar years. For women at high risk, Cervical Cancer Screening is covered once a year; the code for Medicare preventive high risk cervical cancer screening must be submitted on the claim.

For more information about Medicare-covered preventive services (including covered CPT codes), a Quick Reference Guide is available at [www.cms.gov](http://www.cms.gov)

## **Annual Wellness Visits and Routine Annual Physical Exams are not the same thing.**

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Annual Wellness Visits have no cost to the Member; Routine Annual Physical Examinations charge a PCP copayment.

- The Routine Annual Physical Exam is a supplemental non-Medicare benefit meant to complement the Medicare-covered Annual Wellness Visit. This benefit is limited to a physical exam, and it is not a substitute for an Annual Wellness Visit.
- The Annual Routine Physical Examination may be performed during the same visit as an Annual Wellness Visit or they may be done separately on different dates of service.

## **Medicare Coverage of Immunizations and Vaccines**

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Influenza, pneumonia, and for people at risk, hepatitis B immunizations are covered by Medicare Part B and Geisinger Gold Medical Benefits. These vaccines are covered when they are supplied and administered in the provider's office.

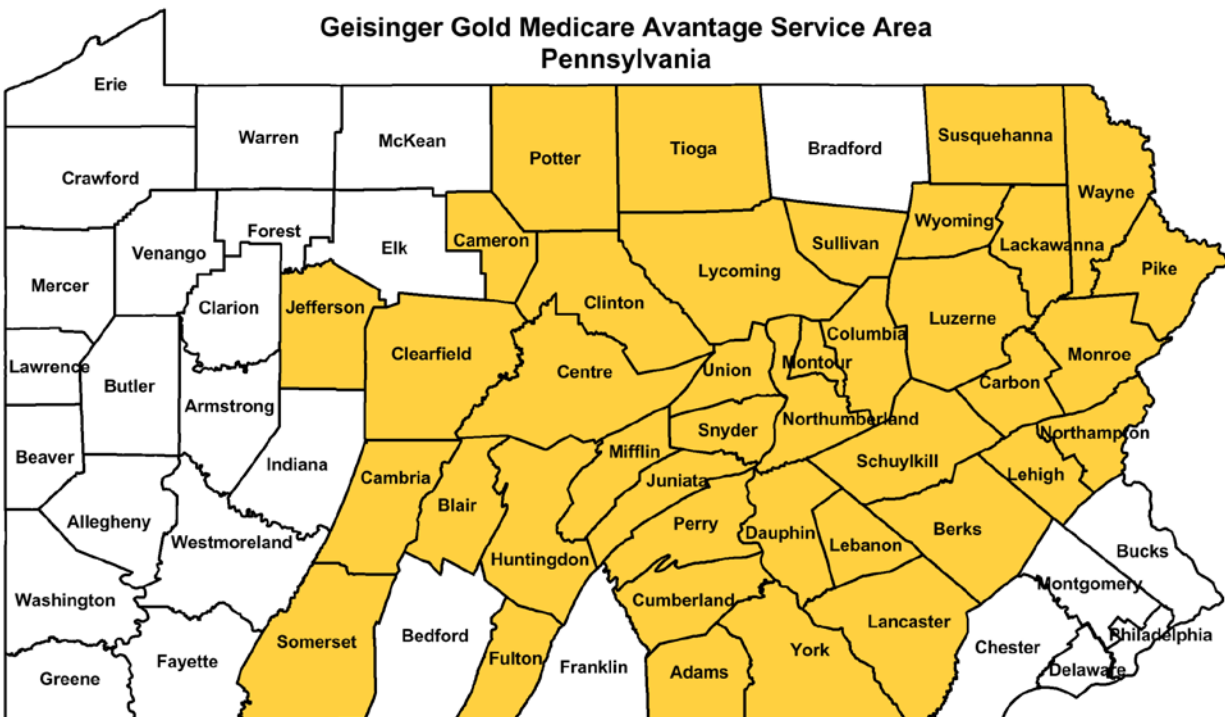
**Other vaccines are covered under Geisinger Gold medical benefits (Medicare Part B) ONLY when they are given to treat an injury or an exposure to a disease or condition.** Examples would include a tetanus shot if the patient steps on a rusty nail, rabies shots if bitten by an animal, the Measles, Mumps, Rubella (MMR) shot if the patient were exposed to someone who had Measles, etc.

Routine, scheduled preventive vaccines that are not covered by Geisinger Gold Medical Benefits (Medicare Part B) are covered under the **Medicare Part D Prescription Drug benefit.** Vaccine coverage is limited to the allowed Pharmacy cost minus the member's Part D copayment.

### **There are several ways Geisinger Gold members can get routine, scheduled vaccines that are covered under Part D:**

- The member can have the vaccine administered at a network pharmacy;
- Members can purchase the vaccine at a network pharmacy (with a valid prescription) and take it to the provider's office for administration;
- Members can pay the office for the vaccination up front, and submit the receipt to Geisinger Gold Part D for reimbursement under their Part D drug coverage;
- If your office participates in the online Part D vaccine billing service called eDispense, you may bill the vaccine to the member's Geisinger Gold Part D coverage through eDispense.
- **More information about Medicare's coverage of immunizations and vaccines is available at [www.cms.gov](http://www.cms.gov)**

## **Geisinger Gold 2014 Service Area**



**Medicare beneficiaries must live in the above service area to enroll in Classic, Preferred, and Secure plans.**

**Please note:**

- Classic 4 and Preferred 3 plans are only offered in Carbon, Lehigh, and Northampton counties and replace Classic 3 and Preferred 1 in those counties.
- Reserve plan is available statewide.