

OPERATIONS BULLETIN



Date: March, 2016

To: Geisinger Gold Participating Providers

Re: Geisinger Gold 2016

Geisinger Gold 2016 Product Line

Geisinger Gold serves more than 79,000 members in 40 counties throughout Pennsylvania and has held the highest accreditation from the National Committee for Quality Assurance (NCQA) since 2006. A physician-led organization focused on keeping members healthy and delivering the best value in health care coverage, Geisinger Gold currently contracts with more than 90 area hospitals, 29,000 providers, and 3,000 pharmacies.

Plans for 2016 include:

- Classic Advantage (HMO)
- Classic Advantage Rx (HMO)
- Classic Complete Rx (HMO)*
- Preferred Advantage Rx (PPO)*
- Preferred Complete Rx (PPO)*
- Secure Rx (HMO SNP)
- Classic REHP (HMO)

Medicare Part D Rx Drug Coverage

Classic Advantage Rx, Classic Complete Rx, Preferred Advantage Rx, and Preferred Complete Rx offer \$0 Deductible prescription drug coverage. This benefit includes fixed, predictable copays in the initial coverage level and cost sharing up to the coverage gap. Members will pay a \$3 co-pay for a 30 day supply of tier 1 generic drugs through the coverage gap. Members will pay 45% for brand drugs and no more than 58% for other generic drugs through the coverage gap.

Generally, members in Secure Rx will not be subject to a \$360 deductible and will have predictable co-pays through the coverage gap. Depending on the level of Extra Help Secure Rx members get from Medicare, they will pay low, predictable copays for their medications right away. Secure Rx members who do not receive “extra help” have a \$360 deductible on their prescription drug coverage.

Classic Advantage and Classic REHP do not include Part D Rx drug coverage.

Supplemental Benefits

Classic Advantage, Classic Advantage Rx, and Secure Rx plans feature built-in supplemental benefit coverage for the following:

- preventive dental
- routine vision exams and eyewear
- hearing exams and hearing aids
- routine nail trimming
- 24 hour nurse line
- quarterly fitness reimbursement

*Geisinger Gold Health+

Optional supplemental benefits can be purchased for these plans through Geisinger Gold Health+.

Geisinger Gold Health+ benefits include:

- Routine vision (\$20 copay for 1 routine exam with refraction per year; \$100 eyewear allowance per year)
- Routine hearing (\$20 copay for 1 routine exam per year; \$250 hearing aid & fitting allowance per year)
- Fitness Reimbursement (up to \$90 allowance per quarter)
- Routine dental (\$250 allowance for 1 exam and 1 cleaning per 6 months and 1 x-ray per year)

Please note: The Geisinger Gold Health + package is indicated on the back of the member Identification card with a dummy rider that ends in “R”. Members who don’t elect the Health + package will have a dummy rider on the back of the card indicating an “X”.

Medicare Covered Preventive Services*

The following Medicare covered preventive services are available at no cost to Gold members:

- Abdominal Aortic Aneurysm Screening
- Annual Wellness Visit
- Bone Mass Measurement
- Cancer Screenings *
- Cardiovascular Disease Screening
- Cardiovascular Disease Behavioral Therapy
- Depression Screening
- Diabetes Screenings
- Diabetes Self-Management Training
- Glaucoma Screening
- HIV Screening
- Immunizations covered under Medicare Part B
- Medical Nutritional Therapy
- Welcome to Medicare Exam
- Screening & Counseling Alcohol Misuse
- Screening for Sexually Transmitted Infections
- Tobacco Use Cessation Counseling
- Obesity Screening & Counseling

** The list above is not a complete list of \$0 preventive services covered by Medicare. Some categories have limits on covered procedures. For a complete list and associated coding and coverage information, visit <https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/>. Please note that Geisinger Gold frequency of coverage for most preventive services is based on calendar year(s) rather than months.*

Learn more about Medicare-covered \$0 Copayment Preventive Services on Medicare's Preventive Services Provider Resource Page: <https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/ProviderResources.html>

IMPORTANT – Please Note: Only the specific procedure and diagnosis codes designated by Medicare for these preventive services are covered. Claims submitted with codes that are not covered by Medicare for the preventive procedure furnished are invalid and will be returned with a request to resubmit the claim with correct Medicare coding. The primary diagnosis code listed for the service must be one of the ICD-10 codes covered by Medicare for the preventive service being furnished.

Medicare-Covered Preventive Cervical Cancer Screening (Screening Pelvic Exams and Pap Tests)

A reminder - Coverage of Screening Pelvic Exams and Screening Pap Tests is limited to once every two years for those at normal risk, and for those at high risk, once a year. Medicare no longer allows Medicare Advantage Plans to cover screening Pap tests and screening pelvic exams (the Preventive Cervical Cancer Screening Benefit) more frequently than they are covered by Original Medicare.

High risk Screening Pelvic Exams and Pap Tests services must always list one of the specific high risk cervical cancer screening ICD-10 codes as the primary diagnosis code on the claim.

Podiatry Services

Geisinger Gold provides coverage of Medicare-covered Podiatry Services, plus a non-Medicare-covered supplemental benefit that covers routine nail trimming up to four times a year.

All Medicare-covered services, including routine foot care, charge the plan's Podiatry Services copayment. This includes nail debridement. More information about Medicare-covered podiatry services is available at www.CMS.gov.

No copayment is charged for the supplemental nail trimming benefit (CPT/HCPCS Codes 11719 & G0127), covered up to 4 times per year. Z41.8 is the covered ICD-10 code for this supplemental benefit service. The nail trim benefit is limited to reducing the length of the nail by trimming, clipping, or filing the free edge (the end of the toenail). **Nail Debridement and other routine foot care services are not covered by the \$0 Copayment supplemental nail trimming benefit.**

Geisinger Gold Classic (HMO) plans

Geisinger Gold Classic (HMO) plans are HMO plans that offer more comprehensive protection and lower out-of-pocket costs than Original Medicare. Members must choose a Primary Care Physician to coordinate their medical care. Covered services, including hospitalization, routine office visits, physicals, immunizations, diagnostic tests and x-rays, have affordable, predictable costs.

Classic Advantage

| | | | |
|---|---|---|--|
| GEISINGER GOLD® | | Classic Advantage HMO A Medicare Advantage Plan | |
| First Name Last Name ID #: 12345678901 Medical Record #: 12345678 | CMS:HXXXX-XXX Issuer: 80840 RxBin: 003585 RxPCN: ASPROD1 | | |
| Primary Care: XXXX XXXXXXXXXXXXXXXXXX Office #: 123/456-7891 Tel-A-Nurse #: 877-543-5061 | PCP Copay \$5 Spec Copay \$20 ER Copay \$75 | | |
|  | | | |
| x www.GeisingerGold.com | | | |

Classic Advantage Rx

| | | | |
|---|---|--|--|
| GEISINGER GOLD® | | Classic Advantage Rx HMO A Medicare Advantage Plan | |
| First Name Last Name ID #: 12345678901 Medical Record #: 12345678 | CMS:HXXXX-XXX Issuer: 80840 RxBin: 015574 RxPCN: ASPROD1 | | |
| Primary Care: XXXX XXXXXXXXXXXXXXXXXX Office #: 123/456-7891 Tel-A-Nurse #: 877-543-5061 | PCP Copay \$5 Spec Copay \$20 ER Copay \$75 | | |
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| x www.GeisingerGold.com | | | |

Classic Complete Rx

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|---|---|---|--|
| GEISINGER GOLD® | | Classic Complete Rx HMO A Medicare Advantage Plan | |
| First Name Last Name ID #: 12345678901 Medical Record #: 12345678 | CMS:HXXXX-XXX Issuer: 80840 RxBin: 015574 RxPCN: ASPROD1 | | |
| Primary Care: XXXX XXXXXXXXXXXXXXXXXX Office #: 123/456-7891 Tel-A-Nurse #: 877-543-5061 | PCP Copay \$5 Spec Copay \$30 ER Copay \$75 | | |
|  | | | |
| x www.GeisingerGold.com | | | |

Geisinger Gold Preferred (PPO) plans

Geisinger Gold Preferred (PPO) are PPO plans that offer predictable costs and the freedom for members to choose any doctor or hospital they wish. No Primary Care Physician selection or referrals are needed. As a new plan feature for 2016, covered services can be obtained from either in-network or out-of-network providers at the same cost.

Preferred Advantage Rx

| | | | |
|--|---|--|--|
| GEISINGER GOLD® | | Preferred Advantage Rx PPO No Referral A Medicare Advantage Plan | |
| First Name Last Name ID #: 12345678901 Medical Record #: 12345678 | CMS:HXXXX-XXX Issuer: 80840 RxBin: 015574 RxPCN: ASPROD1 | | |
| Primary Care: XXXX XXXXXXXXXXXXXXXXXX Office #: 123/456-7891 Tel-A-Nurse #: 877-543-5061 Providers: DO NOT BILL MEDICARE | In-Network PCP Copay \$5 In-Network Spec Copay \$25 ER Copay \$75 | | |
|  | | | |
| x www.GeisingerGold.com | | | |


Preferred Complete Rx

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|--|---|---|--|
| GEISINGER GOLD® | | Preferred Complete Rx PPO No Referral A Medicare Advantage Plan | |
| First Name Last Name ID #: 12345678901 Medical Record #: 12345678 | CMS:HXXXX-XXX Issuer: 80840 RxBin: 015574 RxPCN: ASPROD1 | | |
| Primary Care: XXXX XXXXXXXXXXXXXXXXXX Office #: 123/456-7891 Tel-A-Nurse #: 877-543-5061 Providers: DO NOT BILL MEDICARE | In-Network PCP Copay \$5 In-Network Spec Copay \$40 ER Copay \$75 | | |
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| x www.GeisingerGold.com | | | |

Geisinger Gold Secure (HMO SNP) plan

Geisinger Gold Secure (HMO SNP) is a Special Needs HMO plan for individuals who meet certain income or need-based criteria and are fully eligible for both Medicare and Medicaid. Prescription drug coverage is included.


Secure Rx

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|---|---|---|--|
| GEISINGER GOLD® | | Secure Rx HMO SNP A Medicare Advantage Plan | |
| First Name Last Name ID #: 12345678901 Medical Record #: 12345678 | CMS:HXXXX-XXX Issuer: 80840 RxBin: 015574 RxPCN: ASPROD1 | | |
| Primary Care: XXXX XXXXXXXXXXXXXXXXXX Office #: 123/456-7891 Tel-A-Nurse #: 877-543-5061 | PCP Copay \$0 Specialist 20% ER Copay \$75 | | |
|  | | | |
| x www.GeisingerGold.com | | | |

Geisinger Gold Classic REHP (HMO) plan

Geisinger Gold Classic REHP (HMO) plan is available to eligible Commonwealth of Pennsylvania retirees. Prescription drug coverage is facilitated through a separate REHP Prescription Drug plan provided by a different insurance carrier.

Classic REHP

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|---|---|---|--|-------------|
| GEISINGER GOLD® | | Classic (HMO) A Customized Medicare Advantage Plan | | REHP |
| First Name Last Name ID #: 12345678901 Medical Record #: 12345678 | CMS:HXXXX-XXX Issuer: 80840 RxBin: 003585 RxPCN: ASPROD1 | | | |
| Primary Care: XXXX XXXXXXXXXXXXXXXXXX Office #: 123/456-7891 Tel-A-Nurse #: 877-543-5061 | PCP Copay \$10 Spec Copay \$15 ER Copay \$50 | | | |
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| www.GeisingerGold.com | | | | |

Classic Advantage Rx (HMO) & Classic Complete Rx (HMO)

| | Classic Advantage Rx | Classic Complete Rx |
|--|--|--|
| Deductible | \$0 | \$0 |
| Out of Pocket Max | \$3,400 | \$5,900 |
| PCP | \$5 | \$5 |
| Physician Specialist | \$20 | \$30 |
| Inpatient Hospital - Acute | \$125/day (days 1-5) \$0/day (days 6-90) | \$180/day (days 1-9) \$0/day (days 10-90) |
| Inpatient Psychiatric Hospital | \$125/day (days 1-5) \$0/day (days 6-90) | \$170/day (days 1-9) \$0/day (days 10-90) |
| SNF (no prior hospital stay required) | \$0/day (days 1-20) \$160/day (days 21-42) \$0/day (days 43-100) | \$0/day (days 1-20) \$160/day (days 21-57) \$0/day (days 58-100) |
| Cardiac/Pulmonary Rehab | \$10 per day | \$10 per day |
| Emergency Care | \$75 (Waived if admitted) | \$75 (Waived if admitted) |
| Urgent Care | \$20 (Waived if admitted) | \$30 (Waived if admitted) |
| Worldwide Emergency Coverage | \$75 (Waived if admitted) \$25,000 worldwide benefit limit | \$75 (Waived if admitted) \$25,000 worldwide benefit limit |
| Home Health Services (includes related medical supplies) | \$0 | \$0 |
| Chiropractic Services (Original Medicare Benefit) | \$20 | \$20 |
| Podiatry (Original Medicare Benefits, including Nail Debridement) | \$20 | \$30 |
| Podiatry - Routine Nail Trimming (Non-Medicare-covered, preventive) | \$0; 4 per year | \$0; 4 per year |
| Occupational Therapy | \$10 per day | \$30 per day |
| Physical & Speech Therapy | \$10 per day | \$30 per day |
| Outpatient All Other Diagnostic Procedures/Tests/Supplies | \$5 | \$5 |
| Outpatient Lab | \$5 | \$5 |
| Outpatient X-Rays | \$25 | \$30 |
| Outpatient MRI, CT, PET Scans | \$100 | \$225 |
| Outpatient Radiation Therapy | \$25 | \$30 |
| Outpatient All Other Therapeutic Radiology | \$60 | \$60 |
| Ultrasound Diagnostic | \$25 | \$30 |
| Other Diagnostic/General Imaging | \$100 | \$225 |
| Outpatient Hospital/ASC Services | \$200 | \$300 |
| Outpatient Mental Health | \$10 group/\$25 individual | \$10 group/\$25 individual |
| Ambulance | \$100 (Waived if admitted) | \$175 (Waived if admitted) |
| Part B Drugs | 20% | 20% |
| Durable Medical Equipment (DME) | 20% | 20% |
| Prosthetics and Related Supplies | 20% | 20% |

Classic Advantage Rx (HMO) & Classic Complete Rx (HMO)

| | Classic Advantage Rx | Classic Complete Rx |
|--|---|--|
| Diabetic Testing Supplies - Preferred Brand Glucometer | \$0 Preferred Brand Glucometer every 2 years | \$0 Preferred Brand Glucometer every 2 years |
| Diabetic Testing Supplies - All Other | \$0 preferred brand test strips; \$0 lancets & lancet devices (any brand); 20% non-preferred brand test strips & glucometers (prior auth required for non-preferred brand meters & strips over 200 per month) | 20% test strips, lancets & non-preferred brand glucometer (prior auth required for non-preferred brand meters & strips over 200 per month) |
| Diabetes - Therapeutic Shoes or Inserts | 20% | 20% |
| Acupuncture & Other Alternative Therapies - Non-Medicare Covered | Not Covered | Not Covered |
| Supplemental Preventive Health Svc – Annual Routine Physical Exams | \$5 | \$5 |
| Medicare-covered Preventive Services – (See list of covered services on Page 2) | \$0 | \$0 |
| Supplemental Health Management - Fitness Facility Membership | \$90/quarter | Available through optional package |
| Nursing Hotline | \$0 | \$0 |
| Dental Services (Preventive): Oral Exam with or without cleaning | \$20; every 6 months | Available through optional package |
| Dental Services (Preventive): Dental X-Rays | \$20 bitewing only, 1/year; \$30 panoramic & all other types, 1/year | Available through optional package |
| Comprehensive Dental (Original Medicare-Covered Benefit only) | \$0 | \$30 |
| Comprehensive Dental (Non-Medicare Covered) | No Benefit | No Benefit |
| Vision Exam (Medical): \$0 for glaucoma screen - office visit copay may apply | \$20 | \$30 |
| Vision Exam (Routine) | \$20; 1 per year | Available through optional package |
| Original Medicare-Covered Eyewear (Post-Cataract Surgery) | \$0; Only Medicare-covered (Basic frames and lenses) | \$0; Only Medicare-covered (Basic frames and lenses) |
| Routine Eyewear, Non-Medicare Covered (Contact Lenses, Eyeglasses, Lenses and Frames) | \$200 benefit max every 2 years | Available through optional package |
| Hearing Exams - Diagnostic Only | \$20 | \$30 |
| Routine Hearing Exams | \$20; 1 per year | Available through optional package |
| Hearing Aids/Fitting for Hearing Aids | \$800 maximum benefit for 1 hearing aid every 3 years (fitting/testing fall under this limit) | Available through optional package |
| Part D Deductible | \$0 | \$0 |
| Tier 1 Preferred Generics (30 day) | \$3 | \$3 |
| Tier 2 Non-preferred Generics (30 day) | \$20 | \$20 |
| Tier 3 Preferred Brand (30 day) | \$47 | \$47 |
| Tier 4 Non-preferred Brand (30 day) | \$100 | \$100 |
| Tier 5 Specialty (30 day) | 33% | 33% |
| Gap Coverage - Tier 1 Generic | \$3 | \$3 |

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

| | Preferred Advantage Rx | Preferred Complete Rx |
|--|--|--|
| Deductible | \$0 | \$0 |
| | In-network or Out-of-network | In-network or Out-of-network |
| Out of Pocket Max | \$6,700 | \$6,700 |
| PCP | \$5 | \$5 |
| Physician Specialist | \$25 | \$40 |
| Inpatient Hospital - Acute | \$200 per stay | \$180 (days 1-9) \$0/day (days 10-90) |
| Inpatient Psychiatric Hospital | \$200 per stay | \$190 (days 1-8) \$0/day (days 9-90) |
| SNF (no prior hospital stay required) | \$0/day (days 1-20) \$160/day (days 21-62) \$0/day (days 63-100) | \$0/day (days 1-20) \$160/day (days 21-62) \$0/day (days 63-100) |
| Cardiac/Pulmonary Rehab | \$10 per day | \$10 per day |
| Emergency Care | \$75 (Waived if admitted) | \$75 (Waived if admitted) |
| Urgent Care | \$25 (Waived if admitted) | \$40 (Waived if admitted) |
| Worldwide Emergency Coverage | \$75 Waived if admitted, \$25,000 worldwide benefit limit | \$75 Waived if admitted, \$25,000 worldwide benefit limit |
| Home Health Services (includes related medical supplies) | \$0 | \$0 |
| Chiropractic Services (Original Medicare Benefit) | \$20 | \$20 |
| Podiatry (Original Medicare Benefits, including Nail Debridement) | \$25 | \$40 |
| Podiatry - Routine Nail Trimming (Non-Medicare-covered, preventive) | \$0 /up to 4 visits per year | \$0 /up to 4 visits per year |
| Occupational Therapy | \$25 per day | \$40 per day |
| Physical & Speech Therapy | \$25 per day | \$40 per day |
| Outpatient All Other Diagnostic Procedures/Tests/Supplies | \$20 | \$25 |
| Outpatient Lab | \$20 | \$25 |
| Outpatient X-Rays | \$20 | \$35 |
| Outpatient MRI, CT, PET Scans | \$175 | \$260 |
| Outpatient Radiation Therapy | \$25 | \$35 |
| Outpatient All Other Therapeutic Radiology | \$60 | \$60 |
| Ultrasound Diagnostic | \$25 | \$35 |
| Other Diagnostic/General Imaging | \$25 | \$35 |
| Outpatient Hospital Surgery/ASC | \$225 | \$325 |
| Outpatient Mental Health | \$10 group/\$25 individual | \$10 group/\$25 individual |
| Ambulance | \$200 (Waived if admitted) | \$190 (Waived if admitted) |
| Part B Drugs | 20% | 20% |
| Durable Medical Equipment (DME) | 20% | 20% |
| Prosthetics and Related Supplies | 20% | 20% |
| Diabetic Testing Supplies - Preferred Brand Glucometer | \$0 Preferred Brand Glucometer every 2 years | \$0 Preferred Brand Glucometer every 2 years |

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

| | Preferred Advantage Rx | Preferred Complete Rx |
|--|--|--|
| | In-network or Out-of-network | In-network or Out-of-network |
| Diabetic Testing Supplies - All Other | 20% test strips, lancets & non-preferred brand glucometer (prior auth required for non-preferred brand meters & strips over 200 per month) | 20% test strips, lancets & non-preferred brand glucometer (prior auth required for non-preferred brand meters & strips over 200 per month) |
| Diabetes - Therapeutic Shoes or Inserts | 20% | 20% |
| Acupuncture & Other Alternative Therapies (Non-Medicare Covered) | Not Covered | Not Covered |
| Medicare-covered Preventive Services – (See list of covered services on Page 2) | \$0 | \$0 |
| Supplemental Preventive Health Svc - Annual Routine Physical Exams | \$5 | \$5 |
| Supplemental Health Mgmt Programs-Fitness Facility Membership | Available through optional package | Available through optional package |
| Nursing Hotline | \$0 | \$0 |
| Dental Services (Preventive): Oral Exam with or without cleaning | Available through optional package | Available through optional package |
| Dental Services (Preventive): Dental X-Rays | Available through optional package | Available through optional package |
| Comprehensive Dental (Original Medicare-Covered Services only) | \$25 | \$40 |
| Vision Exam (Medical): \$0 for glaucoma screen - office visit copay may apply | \$25 | \$40 |
| Vision Exam (Routine) | Available through optional package | Available through optional package |
| Original Medicare-Covered Eyewear (Post-Cataract Surgery) | \$0 Only Medicare-covered (Basic frames & lenses) | \$0 Only Medicare-covered (Basic frames & lenses) |
| Routine Eyewear, Non-Medicare Covered (Contact Lenses, Eyeglasses, Lenses and Frames) | Available through optional package | Available through optional package |
| Hearing Exams - Diagnostic Only | \$25 | \$40 |
| Routine Hearing Exams | Available through optional package | Available through optional package |
| Hearing Aids/Fitting for Hearing Aids | Available through optional package | Available through optional package |
| Part D Deductible | \$0 | \$0 |
| Tier 1 Preferred Generics (30 day) | \$3 | \$3 |
| Tier 2 Non-preferred Generics (30 day) | \$20 | \$20 |
| Tier 3 Preferred Brand (30 day) | \$47 | \$47 |
| Tier 4 Non-preferred Brand (30 day) | \$100 | \$100 |
| Tier 5 Specialty (30 day) | 33% | 33% |
| Gap Coverage - Tier 1 Generic | \$3 | \$3 |

Secure Rx (HMO SNP) – A Dual Eligible Special Needs Plan

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|--|--|
| Deductible | None to member Medicare FFS Part A deductible billed to Medicaid No deductible on Part B |
| Out of Pocket Max | \$6,700 |
| PCP | \$0 to member \$0 copay for PCP not billed to Medicaid |
| Physician Specialist | \$0 to member - 20% Medicare FFS cost-sharing billed to Medicaid |
| Inpatient Hospital - Acute | \$0 to member Medicare FFS Part A deductible and Part A cost-sharing billed to Medicaid |
| Inpatient Psychiatric Hospital | \$0 to member Medicare FFS Part A deductible and Part A cost-sharing billed to Medicaid |
| SNF | \$0 to member Medicare FFS Part A deductible and Part A cost-sharing billed to Medicaid |
| Cardiac/Pulmonary Rehab | \$0 to member - 20% Medicare FFS cost-sharing billed to Medicaid |
| Emergency Care | \$0 to member \$75 copay billed to Medicaid |
| Urgent Care | \$0 to member - 20% Medicare FFS cost-sharing billed to Medicaid |
| Worldwide Emergency Coverage | \$0 |
| Home Health Services (includes related medical supplies) | \$0 |
| Chiropractic Services (Original Medicare Benefit) | \$0 to member - 20% Medicare FFS cost-sharing billed to Medicaid |
| Podiatry (Original Medicare Benefits, including Nail Debridement) | \$0 to member - 20% Medicare FFS cost-sharing billed to Medicaid |
| Podiatry - Routine Nail Trimming (Non-Medicare-covered, preventive) | \$0 |
| Occupational Therapy | \$0 to member - 20% Medicare FFS cost-sharing billed to Medicaid |
| Physical & Speech Therapy | \$0 to member - 20% Medicare FFS cost-sharing billed to Medicaid |
| Outpatient All Other Diagnostic Procedures/ Tests | \$0 to member - 20% Medicare FFS cost-sharing billed to Medicaid |
| Outpatient Lab | \$0 to member - 20% Medicare FFS cost-sharing billed to Medicaid |
| Outpatient X-Rays | \$0 to member - 20% Medicare FFS cost-sharing billed to Medicaid |
| Outpatient MRI, CT, PET Scans | \$0 to member - 20% Medicare FFS cost-sharing billed to Medicaid |
| Outpatient Radiation Therapy, Nuclear Medicine | \$0 to member - 20% Medicare FFS cost-sharing billed to Medicaid |
| Outpatient All Other Therapeutic Radiology | \$0 to member - 20% Medicare FFS cost-sharing billed to Medicaid |
| Ultrasound Diagnostic | \$0 to member - 20% Medicare FFS cost-sharing billed to Medicaid |
| Other Diagnostic/General Imaging | \$0 to member - 20% Medicare FFS cost-sharing billed to Medicaid |
| Outpatient Hospital/ASC Services | \$0 to member - 20% Medicare FFS cost-sharing billed to Medicaid |
| Outpatient Mental Health | \$0 to member - 20% Medicare FFS cost-sharing billed to Medicaid |
| Ambulance | \$0 to member - 20% Medicare FFS cost-sharing billed to Medicaid |
| Part B Drugs | \$0 to member - 20% Medicare FFS cost-sharing billed to Medicaid |
| Durable Medical Equipment (DME) | \$0 to member - 20% Medicare FFS cost-sharing billed to Medicaid |
| Prosthetics and Related Supplies | \$0 to member - 20% Medicare FFS cost-sharing billed to Medicaid |

Secure Rx (HMO SNP) – A Dual Eligible Special Needs Plan

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|--|---|
| Diabetic Testing Supplies - Preferred Brand Glucometer | \$0 Preferred Brand Glucometer every 2 years |
| Diabetic Testing Supplies - All Other (strips, lancets & non-preferred brand meters) | \$0 to member - 20% Medicare FFS cost-sharing billed to Medicaid (prior auth required on non-preferred brand strips & meters) |
| Diabetes - Therapeutic Shoes or Inserts | \$0 to member - 20% Medicare FFS cost-sharing billed to Medicaid |
| Acupuncture & Other Alternative Therapies - Non-Medicare Covered | Not Covered |
| Supplemental Preventive Health Svc - Annual Routine Physical Exams | \$0 |
| Medicare-covered Preventive Services – (See list of covered services on Page 2) | \$0 |
| Supplemental Health Management - Fitness Facility Membership | Up to \$120 allowance per quarter |
| Nursing Hotline | \$0 |
| Dental Services (Preventive): Oral Exam with or without cleaning/X-Rays/Dentures | Maximum \$2,000 benefit per year combined for all non-Medicare dental; incl. exams, cleanings, simple fillings & extractions and dentures |
| Comprehensive Dental (Original Medicare-Covered Benefit only) | \$0 to member - 20% Medicare FFS cost-sharing billed to Medicaid |
| Comprehensive Dental (Non-Medicare Covered) | Not Covered |
| Vision Exam (Medical): \$0 for glaucoma screen - office visit copay may apply | \$0 to member - 20% Medicare FFS cost-sharing billed to Medicaid |
| Vision Exam (Routine) | \$0; 1 per year |
| Original Medicare-Covered Eyewear (Post-Cataract Surgery) | \$0 to member - 20% Medicare FFS cost-sharing billed to Medicaid |
| Eyewear: Routine Eyewear, Non-Medicare Covered. Contact Lenses, Eyeglasses, Lenses and Frames | \$0 to member - \$200 maximum benefit every 2 years |
| Hearing Exams - Diagnostic Only | \$0 to member - 20% Medicare FFS cost-sharing billed to Medicaid |
| Routine Hearing Exams | \$0 to member; 1 per year |
| Hearing Aids/Fitting for Hearing Aids (includes fitting and testing) | \$0 to member / \$600 maximum benefit for 1 hearing aid every 3 years |
| Part D Prescription Drugs | Part D drugs covered with Medicare LIS cost sharing & premium subsidies. |
| Over-the-Counter-Drugs | \$50 allowance per quarter |

All Secure Rx members have Medicare and full Medicaid benefits. Providers may bill Medicaid as a secondary payer. Provider Medicaid participation is 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.

Important Reminder from CMS regarding prohibited billing of Cost Sharing to Dual Eligible QMB Beneficiaries

Qualified Medicare Beneficiaries (QMBs) are individuals receiving Medicare that also qualify for full Medicaid Benefits. Medicaid pays Medicare premiums and Medicare cost sharing for QMBs. Under the Social Security Act, Medicare and Medicaid payments you receive for furnishing services to a QMB are considered payments in full. You may not balance bill QMBs for any Medicare cost sharing (including deductibles, coinsurance, and copayments) for these services. You are subject to Medicare sanctions if you bill a QMB for amounts above the Medicare (or Medicare Advantage Plan) and Medicaid payments (even when Medicaid pays nothing). **These regulations apply to all Medicare-enrolled providers, including Providers furnishing Medicare-covered care to members of Medicare Advantage Plans, including those who do not accept Medicaid.**

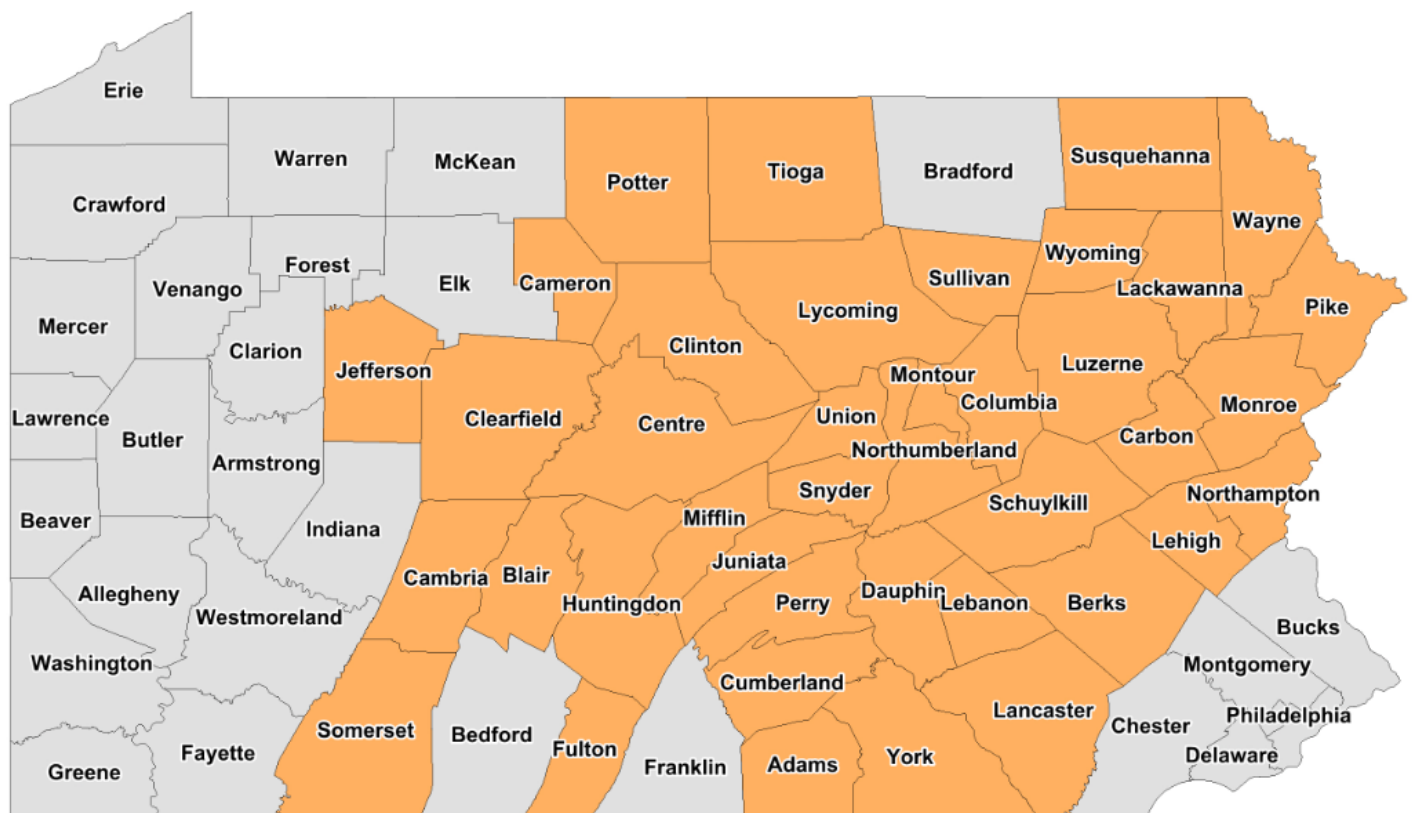
REHP (HMO)

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|--|---|
| Deductible | \$0 |
| Out of Pocket Max | \$2,500 |
| PCP | \$10 |
| Physician Specialist | \$15 |
| Inpatient Hospital - Acute | \$0 (no limit on number of days for each Medicare covered stay) |
| Inpatient Psychiatric Hospital | \$0 (no limit on number of days for each Medicare covered stay) |
| SNF | \$0/day (days 1-100) |
| Cardiac/Pulmonary Rehab | \$10 per day |
| Emergency Care | \$50 |
| Urgent Care | \$50 |
| Worldwide Emergency Coverage | \$50 |
| Home Health Services (includes related medical supplies) | \$0 |
| Chiropractic Services (Original Medicare Benefit) | \$15 |
| Podiatry (Original Medicare Benefits, including Nail Debridement) | \$15 |
| Occupational Therapy | \$10 |
| Physical & Speech Therapy | \$10 |
| Outpatient All Other Diagnostic Procedures/ Tests | \$0 |
| Outpatient Lab | \$0 |
| Outpatient X-Rays | \$0 |
| Outpatient MRI, CT, PET Scans | \$0 |
| Outpatient Radiation Therapy, Nuclear Medicine | \$0 |
| Outpatient All Other Therapeutic Radiology | \$0 |
| Ultrasound Diagnostic | \$0 |
| Other Diagnostic/General Imaging | \$0 |
| Outpatient Hospital/ASC Services | \$0 |
| Outpatient Mental Health | \$15 (group & individual) |
| Ambulance | \$0 |
| Part B Drugs | \$0 |
| Durable Medical Equipment (DME) | \$0 |
| Prosthetics and Related Supplies | \$0 |
| Diabetic Testing Supplies - Preferred Brand Glucometer | \$0 |
| Diabetic Testing Supplies - All Other | \$0 |
| Diabetes - Therapeutic Shoes or Inserts | \$0 |
| Acupuncture & Other Alternative Therapies - Non-Medicare Covered | Not covered |
| Medicare-covered Preventive Services – (See list of covered services on Page 2) | \$0 |
| Supplemental Preventive Health Svc - Annual Routine Physical Exams | \$0 |
| Supplemental Health Management - Fitness Facility Membership | \$90/quarter |
| Nursing Hotline | \$0 |

REHP (HMO)

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| Dental Services (Preventive): Oral Exam with or without cleaning/X-Rays/Dentures | No coverage |
| Comprehensive Dental (Original Medicare-Covered Benefit only) | \$0 |
| Comprehensive Dental (Non-Medicare Covered) | No coverage |
| Vision Exam (Medical): \$0 for glaucoma screen - office visit copay may apply | \$0 |
| Vision Exam (Routine) | No coverage |
| Original Medicare-Covered Eyewear (Post-Cataract Surgery) | \$0 |
| Eyewear: Routine Eyewear, Non-Medicare Covered. Contact Lenses, Eyeglasses, Lenses and Frames | No coverage |
| Hearing Exams - Diagnostic Only | \$0 |
| Routine Hearing Exams | No coverage |
| Hearing Aids/Fitting for Hearing Aids | No coverage |
| Part D Prescription Drugs | No coverage |
| Over-the-Counter-Drugs | Not covered |

2016 Geisinger Gold Service Area - Pennsylvania



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