Geisinger

Geisinger Gold Preferred Enhanced Rx (PPO) offered by Geisinger Indemnity Insurance Company

Annual Notice of Changes for 2023

You are currently enrolled as a member of Geisinger Gold Preferred Enhanced Rx (PPO). Next year, there will be changes to the plan's costs and benefits. ***Please see page 5 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at www.GeisingerGold.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.)

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

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2023 Drug List to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies will be in our network next year.

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2023* handbook.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan

- If you don't join another plan by December 7, 2022, you will stay in Geisinger Gold Preferred Enhanced Rx (PPO).
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2023.** This will end your enrollment with Geisinger Gold Preferred Enhanced Rx (PPO).
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- Please contact our Member Services number at 1-800-498-9731 for additional information. TTY users should 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 and speaking). Calls to these numbers are free.

  Our business hours:

October 1– March 31	8 a.m. – 8 p.m. 7 days a week
April 1 – September 30	8 a.m. – 8 p.m. Monday – Friday, 8 a.m. – 2 p.m. Saturday

- Member Services has free language interpreter services available for non-English speakers. Please call the numbers listed in Section 7.1 of this document. We can also give you plan information in braille, audio, large print, or other alternate formats if you need it.
- **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.

About Geisinger Gold Preferred Enhanced Rx (PPO)

- Geisinger Gold Medicare Advantage HMO, PPO, and HMO D-SNP plans are offered by Geisinger Health Plan/Geisinger Indemnity Insurance Company, health plans with a Medicare contract. Continued enrollment in Geisinger Gold depends on contract renewal. Geisinger Health Plan/Geisinger Indemnity Insurance Company are part of Geisinger, an integrated health care delivery and coverage organization.
- When this document says "we," "us," or "our", it means Geisinger Indemnity Insurance Company. When it says "plan" or "our plan," it means Geisinger Gold Preferred Enhanced Rx (PPO).

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Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for Geisinger Gold Preferred Enhanced Rx (PPO) in several important areas. **Please note this is only a summary of costs**.

Cost	2022 (this year)	2023 (next year)
Monthly plan premium*		
*Your premium may be higher than this amount. See Section 1.1 for details.		
Schuylkill	$0	$0

Cost	2022 (this year)	2023 (next year)
	In or out-of-network	**In or out-of-network**
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From network providers: $7,550 From network and out-of-network providers combined: $7,550	From network providers: $7,550 From network and out-of-network providers combined: $7,550
Doctor office visits	Primary care visits: $5 copayment per visit Specialist visits: $35 copayment per visit	Primary care visits: $0 copayment per visit Specialist visits: $35 copayment per visit
Inpatient hospital stays	You pay $325 copayment per stay For calendar year 2022, the inpatient hospital stays benefit will have a service specific maximum out-of-pocket of $975. This means you will not pay any more than $975 for inpatient hospital stays.	You pay $325 copayment per stay For calendar year 2023, the inpatient hospital stays benefit will have a service specific maximum out-of-pocket of $975. This means you will not pay any more than $975 for inpatient hospital stays.
Inpatient hospital stays (Psychiatric)	You pay $325 copayment per stay For calendar year 2022, the inpatient hospital stays (Psychiatric) benefit will have a service specific maximum out-of-pocket of $975. This means you will not pay any more than $975 for inpatient mental health care.	You pay $325 copayment per stay For calendar year 2023, the inpatient hospital stays (Psychiatric) benefit will have a service specific maximum out-of-pocket of $975. This means you will not pay any more than $975 for inpatient mental health care.

Cost	2022 (this year)	2023 (next year)
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $0 Cost sharing during the Initial Coverage Stage:	Deductible: $0 Cost sharing during the Initial Coverage Stage:
Tier 1: Preferred Generic		
30-day retail copay	$0	$0
100-day retail copay	$0	$0
100-day mail order copay	$0	$0
Tier 2: Generic		
30-day retail copay	$5.00	$5.00
100-day retail copay	$12.50	$12.50
100-day mail order copay	$0	$0
Tier 3: Preferred Brand		
30-day retail copay	$47.00	$47.00
100-day retail copay	$117.50	$117.50
100-day mail order copay	$70.50	$70.50
Tier 4: Non-Preferred Brand		
30-day retail copay	$100.00	$100.00
100-day retail copay	$250.00	$250.00
100-day mail order copay	$150.00	$150.00
Tier 5: Specialty Tier		
30-day retail copay	33%	33%
100-day retail copay	N/A	N/A
100-day mail order copay	N/A	N/A
Tier 6: Vaccines (Specific)		
30-day retail copay	$0	$0
100-day retail copay	$0	$0
100-day mail order copay	$0	$0
Insulin Saver Program*		
30-day retail copay	$35.00	$35.00
100-day retail copay	$87.50	$87.50
100-day mail order copay	$52.50	$52.50

Cost	2022 (this year)	2023 (next year)
	Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage)	Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage)

* To find out which drugs are Select Insulins, review the most recent Drug List we sent you in the mail. You can identify Select Insulins by looking for the "SI" abbreviation in the Requirements/Limits column within the Drug List. If you have questions about the Drug List, you can also call Pharmacy Member Services (phone numbers for Pharmacy Member Services are listed in Section 7.1 of this document.)

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost **Monthly premium** (You must also continue to pay your Medicare Part B premium.)	2022 (this year)	2023 (next year)
Schuylkill	$0	$0

Part B Premium Reduction

Eligible members ***may*** receive a reduction on their Part B Premium.
For more information, see Chapter 1, Section 4.1 of the Evidence of Coverage.

	2022 (this year)	2023 (next year)
Part B Premium Reduction	$0	$25

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

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

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

Cost	2022 (this year)	2023 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$7,550 Once you have paid $7,550 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.	$7,550 Once you have paid $7,550 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	$7,550 Once you have paid $7,550 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year.	$7,550 Once you have paid $7,550 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

We included a copy of our *Provider Directory* in the envelope with this document. Updated directories are also located on our website at www.GeisingerGold.com. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a directory.

There are changes to our network of providers for next year. **Please review the 2023 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the 2023 *Provider Directory* to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2022 (this year)	2023 (next year)
	In-or-out of network unless noted	**In-or-out of network unless noted**
Annual Routine Physical Exam	You pay a $5 copayment per service	You pay a $0 copayment per service
Cardiac Rehabilitation Services	You pay a $25 copayment per service	You pay a $20 copayment per service
Dental Services Comprehensive/Preventive	$650 combined benefit annually • Fillings • Simple Extractions • Crowns • Non-surgical periodontic services for treatment of gum disease • Root Canals • Dentures • Oral Exams (2 per year) • Routine Cleanings (2 per year) • Dental X-rays (1 per year)	$1,000 combined benefit annually • Fillings • Simple Extractions • Crowns • Non-surgical periodontic services for treatment of gum disease • Root Canals • Dentures • Oral Exams (2 per year) • Routine Cleanings (2 per year) • Dental X-rays (1 per year)

Cost	2022 (this year)	2023 (next year)
	In-or-out of network unless noted	**In-or-out of network unless noted**
Diabetic services and supplies	Continuous Glucose Monitor is ***not*** covered	You pay a 20% coinsurance for continuous Glucose Monitor Continuous Glucose Monitors ***may*** be covered for people who use insulin and meet the medical necessity criteria.
Emergency Care	You pay a $90 copayment (Waived if admitted to the hospital within 3 days for the same condition)	You pay a $95 copayment (Waived if admitted to the hospital within 3 days for the same condition)
Flex Card	Supplemental vision and hearing copayments ***are not*** covered	Supplemental vision and hearing copayments ***are*** covered
Outpatient Diagnostic Procedures, Tests and Supplies	You pay a $20 copayment per day	You pay a $10 copayment per day
Outpatient Lab	You pay a $20 copayment per day	You pay a $10 copayment per day
Outpatient MRI, CT, PET Scans & other Diagnostic Radiological Services	You pay a $300 copayment per day	You pay a $235 copayment per day
Over the Counter (OTC)	Nicotine Replacement Therapy is ***not*** covered.	Nicotine Replacement Therapy ***is*** covered.
Primary Care Physician Services	You pay a $5 copayment per service	You pay a $0 copayment per service

Cost	2022 (this year)	2023 (next year)
	In-or-out of network unless noted	**In-or-out of network unless noted**
Prior Authorizations (applies to in-network only)	Cardiac Rehabilitation Services does ***not*** require Prior Authorization	Cardiac Rehabilitation Services ***require*** Prior Authorization
	Home Health Agency Care does ***not*** require Prior Authorization	Home Health Agency Care ***requires*** Prior Authorization
	Home Infusion Therapy does ***not*** require Prior Authorization	Home Infusion Therapy ***requires*** Prior Authorization
	Opioid Treatment Program Services does ***not*** require Prior Authorization	Opioid Treatment Program Services ***require*** Prior Authorization
	Outpatient Mental Health Services does ***not*** require Prior Authorization	Outpatient Mental Health Services ***require*** Prior Authorization
	Outpatient Rehab Occupational Therapy does ***not*** require Prior Authorization	Outpatient Rehab Occupational Therapy ***requires*** Prior Authorization
	Outpatient Rehab Physical Therapy does ***not*** require Prior Authorization	Outpatient Rehab Physical Therapy ***requires*** Prior Authorization
	Outpatient Rehab Speech Therapy does ***not*** require Prior Authorization	Outpatient Rehab Speech Therapy ***requires*** Prior Authorization
	Outpatient Substance Abuse Services does ***not*** require Prior Authorization	Outpatient Substance Abuse Services ***require*** Prior Authorization
	Pulmonary Rehab does ***not*** require Prior Authorization	Pulmonary Rehab ***requires*** Prior Authorization

Cost	2022 (this year)	2023 (next year)
	In-or-out of network unless noted	**In-or-out of network unless noted**
	Supervised Exercise Therapy does ***not*** require Prior Authorization	Supervised Exercise Therapy ***requires*** Prior Authorization
Pulmonary Rehab	You pay a $25 copayment per service	You pay a $20 copayment per service
Services to Treat Kidney Disease - Renal Dialysis	You pay a 10% coinsurance for home dialysis in-network You pay a 10% coinsurance for home dialysis out-of-network You pay a 20% coinsurance for all other dialysis in-network You pay a 20% coinsurance for all other dialysis out-of-network	You pay a 10% coinsurance for home dialysis in-network You pay a 20% coinsurance for home dialysis out-of-network You pay a 20% coinsurance for all other dialysis in-network You pay a 20% coinsurance for all other dialysis out-of-network
Supervised Exercise Therapy	You pay a $25 copayment per service	You pay a $20 copayment per service
Telehealth E-Visits-Primary Care Physician (Telehealth e-visits available in network only)	You pay a $5 copayment per e-visit	You pay a $0 copayment per e-visit

Cost	2022 (this year)	2023 (next year)
	In-or-out of network unless noted	**In-or-out of network unless noted**
Worldwide Emergency Coverage	You pay a $90 copayment $100,000 Benefit limit per year (Combined Worldwide Emergency/Urgent Coverage) Waive if admitted	You pay a $95 copayment $100,000 Benefit limit per year (Combined Worldwide Emergency/Urgent Coverage) Waive if admitted

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

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

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

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 5 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Pharmacy Member Services for more information.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and you haven't received this insert by September 30, 2022, please call Member Services and ask for the "LIS Rider."

There are four "drug payment stages." The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage The costs in this row are for a one-month (30-day) supply when you fill your prescription at a retail network pharmacy. For information about the costs for a long-term supply at a retail network pharmacy or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply filled at a retail network pharmacy: • Tier 1: (Preferred Generic): You pay $0 per prescription • Tier 2: (Generic): You pay $5 per prescription • Tier 3: (Preferred Brand): You pay $47 per prescription • Tier 4: (Non-Preferred Brand): You pay $100 per prescription • Tier 5: (Specialty Tier): 33% of the total cost • Tier 6: (Vaccine Tier): You pay $0 per prescription • You pay $35 for a one-month supply of select insulins Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage)	Your cost for a one-month supply filled at a retail network pharmacy: • Tier 1: (Preferred Generic): You pay $0 per prescription • Tier 2: (Generic): You pay $5 per prescription • Tier 3: (Preferred Brand): You pay $47 per prescription • Tier 4: (Non-Preferred Brand): You pay $100 per prescription • Tier 5: (Specialty Tier): 33% of the total cost • Tier 6: (Vaccine Tier): You pay $0 per prescription • You pay $35 for a one-month supply of select insulins Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage)

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

o **Important Message About What You Pay for Insulin** - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

o **Getting Help from Medicare - If you chose this plan because you were looking for insulin coverage at $35 a month or less, it is important to know that you may have other options available to you for 2023 at even lower costs because of changes to the Medicare Part D program. Contact Medicare, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week for help comparing your options. TTY users should call 1-877-486-2048.**

o **Additional Resources to Help –** Please contact our Member Services number at 1-800-988-4861 for additional information. TTY users should 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 and speaking).

Our business hours:

October 1– March 31	8 a.m. – 8 p.m. 7 days a week
April 1 – September 30	8 a.m. – 8 p.m. Monday – Friday, 8 a.m. – 2 p.m. Saturday

SECTION 2 Administrative Changes

Description	2022 (this year)	2023 (next year)
Over the counter (OTC) member portal web address	myotccard.com	mybenefitscenter.com

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Geisinger Gold Preferred Enhanced Rx (PPO)

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Geisinger Gold Preferred Enhanced Rx (PPO).

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2023 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- – *OR*– You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2023* handbook, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 7.2).

As a reminder, Geisinger Insurance Indemnity Company offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

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

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2023.

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

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

If you enrolled in a Medicare Advantage Plan for January 1, 2023, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2023.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Pennsylvania, the SHIP is called Pennsylvania Medicare Education and Decision Insight (PA MEDI).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. PA MEDI counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call PA MEDI at 1-800-783-7067. You can learn more about PA MEDI by visiting their website at www.aging.pa.gov/aging-services/medicare-counseling/Pages/default.aspx.

SECTION 6 Programs That Help Pay for Prescription Drugs

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

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
    - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** Pennsylvania has a program called PACE and PACENET that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program.

  Prescription Cost-sharing Assistance for Persons with HIV/AIDS. The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. 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. Medicare Part D prescription drugs that are

also covered by ADAP qualify for prescription cost-sharing assistance through the Special Pharmaceutical Benefits Program (SPBP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-922-9384. If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. For information please call the State Pharmaceutical Benefit Program (SPBP) customer service at 1-800-922-9384. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the State Pharmaceutical Benefits Program (SPBP) Customer Service number at 1-800-922-9384 or send questions to https://www.health.pa.gov/topics/programs/HIV/Pages/Special-Pharmaceutical-Benefits.aspx.

SECTION 7 Questions?

Section 7.1 – Getting Help from Geisinger Gold Preferred Enhanced Rx (PPO)

Questions? We are here to help. Please contact our Member Services number at 1-800-498-9731 or Pharmacy Member Services at 1-800-988-4861 for additional information. TTY users should 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 and speaking). Calls to these numbers are free.

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April 1 – September 30	8 a.m. – 8 p.m. Monday – Friday, 8 a.m. – 2 p.m. Saturday

Read your *2023 Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2023. For details, look in the *2023 Evidence of Coverage* for Geisinger Gold Preferred Enhanced Rx (PPO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.GeisingerGold.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.GeisingerGold.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our list of covered drugs (Formulary/Drug List).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2023*

Read the *Medicare & You 2023* handbook. Every fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.