Geisinger Gold

2019

Quick Reference Guide

For agent use only. Benefits and costs for 2018 are pending CMS approval as of 7/25/18 and are subject to change.

Quick_19

Geisinger Gold Agent/Broker Contact Information

Geisinger Gold is committed to providing you with the information you need to successfully market our Gold Medicare Advantage products. In this quick reference guide, you'll find everything you need to enroll new members into Geisinger Gold products, from complete product information, service areas, who to contact with questions and more.

Please visit the Geisinger Gold broker portal at www.geisingergold.com/broker

Contact Info:

Broker Service Unit • Dual eligibility status • Supplies • Product & commission questions	(866) 488-6653
Enrollment (fax) *	**(570) 271-5970** or (570) 214-1552
Enrollment Address *(applications must be submitted with both Part A & Part B effective dates)*	Geisinger Health Plan Attn: Enrollment 32-29 PO Box 8200 Danville, PA 17821-8200
Customer Service (Gold members only) • Claims • Member Grievances • Provider Network Management	(800) 498-9731
Pharmacy Customer Service (Gold members only)	(800) 988-4861
Social Services Assistants (Gold members only) • Dual eligibility status • Enrolling in Medicare Savings Program, LIS, PACE/PACENET • Assistance with prescriptions	(844) 884-7057
Compliance	(570) 214-9281
Employer Group Retiree Sales	(570) 271-8168
Claims Address	Geisinger Health Plan Attn: Claims 32-29 PO Box 8200 Danville, PA 17821-8200
Geisinger Gold Marketing Central (marketing & sales materials online ordering)	www.geisingergold.com/broker
Geisinger Marketplace	(800) 223-1282

About Geisinger Health Plan and Geisinger Gold

Introduced in 1994, Geisinger Gold serves more than 94,000 members in 43 counties throughout Pennsylvania. We currently contract with more than 125 area hospitals and more than 33,000 providers with nearly 3,000 pharmacies in Pennsylvania to provide medical care for our members. Geisinger Health Plan is a physician-led organization which focuses on keeping members healthy and delivering the best value in health care coverage.

When working with Geisinger Gold, you can expect:

Greater earning potential with prompt payment - Geisinger Gold pays up to the maximum CMS-allowed commissions twice per month. You'll have access to our dedicated broker service unit and highly acclaimed member services. You'll be able to write more business while leaving the service to us.

The Geisinger Gold Marketing Portal is available for our agents and brokers to order collateral and complete trainings and certifications.

Geisinger Health Plan is nationally recognized for our disease management programs. Our Geisinger Gold HMO and PPO plans have both been rated 4 Stars for 2018. Medicare evaluates plans based on a 5-Star rating system. Star Ratings are calculated each year and may change from one year to the next.

Convenience for you and your clients – Geisinger Gold is local to Pennsylvania and committed to serving both the senior population and the agents/brokers who assist them.

For more information, contact the Broker Service Unit at (866) 488-6653 or visit our website at www.geisingergold.com.

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Enrollment forms must be received within 24 hours of the prospective member signing an application

All plans require member to continue paying their monthly Medicare Part B premium, live within the service area, and not have ESRD at the time of enrollment

Medicare Covered Preventive Services

The following Medicare covered preventive services are available to all Gold members at $0 cost sharing:

- Abdominal aortic aneurysm screening
- Alcohol misuse screening and counseling
- Bone mass measurements
- Cancer screenings (breast, cervical, vaginal, colorectal, lung, prostate)
- Cardiovascular disease (behavioral therapy)
- Cardiovascular disease screening
- Depression screening
- Diabetes screening and self-management training
- Glaucoma tests
- Hepatitis C screening
- HIV screening
- Medical nutrition therapy (for beneficiaries with diabetes or kidney disease)
- Obesity screening and counseling
- Sexually transmitted infections screening and counseling
- Tobacco use cessation counseling
- Vaccinations (Hepatitis B, Influenza Virus, Pneumococcal)
- Welcome to Medicare Exam (initial preventive physical exam)
- Yearly wellness visit

2019 Medicare Advantage Provider Network Highlights

Geisinger Gold currently contracts with more than 125 area hospitals, more than 33,000 providers and nearly 3,000 pharmacies throughout Pennsylvania.

Central/Northeast Regions

- Geisinger Health System
- Evangelical Community Hospital
- Wilkes-Barre General Hospital
- Commonwealth Health
- Guthrie Health
- Schuylkill Health
- Pocono Medical Center
- Blue Mountain Health System
- Endless Mountains Health Systems

Geisinger has partnered with WellSpan Health and St. Luke's University Health Network, in order to further improve access to affordable and high quality care.

Southern Regions

- WellSpan Health (includes 6 hospitals)
  - Summit Health (Chambersburg & Waynesboro hospitals in Franklin county)
- St. Luke's University Health Network
- Holy Spirit Health System
- Pinnacle Health System
- Lehigh Valley Health Network
  - Lehigh Valley Hospital – Hazelton (formerly Hazelton General)
- Thomas Jefferson
- Fox Chase Cancer Center
- Pennsylvania Hospital

Western Region

- Geisinger Health System
- Lock Haven Hospital
- UPMC Susquehanna Health
- Allegheny Health Network
- Conemaugh Health System
- Penn Highlands Healthcare
- Mt. Nittany Medical Center

This list is subject to change throughout the year. Visit www.geisingergold.com for the most up-to-date list of our hospitals and providers.

Fitness Reminders

Fitness Center Agreements

Members of Classic Complete Rx, Classic Advantage (Rx), Secure Rx and Health+ have access to the following fitness centers:

- Danville Area Community Center (DACC)
- Berwick YMCA
- Bloomsburg YMCA
- River Valley Regional YMCA (includes Williamsport, Eastern Lycoming, Jersey Shore, Bradford and Tioga branches)
- Lock Haven YMCA
- Greater Scranton YMCA
- Wilkes-Barre YMCA
- Carbondale YMCA

These fitness centers have agreements to bill Geisinger directly up to the plans monthly allowance. Members simply show their Geisinger Gold member ID card at the front desk. Use of other fitness centers will require members to manually submit requests for reimbursement (up to the plans monthly allowance).

Silver & Fit Fitness Network

Members of Preferred Enhanced Rx will have a $25 annual fee when they use in-network Silver & Fit fitness centers. Members will have unlimited access to any facility. The Silver & Fit program is designed for older adults enrolled in Medicare Advantage plans.

Classic Essential Rx
Classic Complete Rx
Classic Advantage
Classic Advantage Rx

HMO Plans

Members must select a Primary Care Physician who works to coordinate their medical care. Members must go to providers and hospitals within the Geisinger Gold network. Classic Complete Rx and Classic Advantage (Rx) members must obtain their covered routine dental services from an Avesis network provider. Referrals are not required to see specialists. **Our service area is expanding to include Bucks, Franklin & Pike counties for 2019.**

Classic Essential Rx

- $0 monthly plan premium across all regions
- No deductible
- Includes prescription drug coverage

Classic Complete Rx

- Moderate monthly plan premium across all regions
- No deductible
- Includes prescription drug coverage
- Supplemental benefits, such as dental, vision, hearing & fitness embedded into plan

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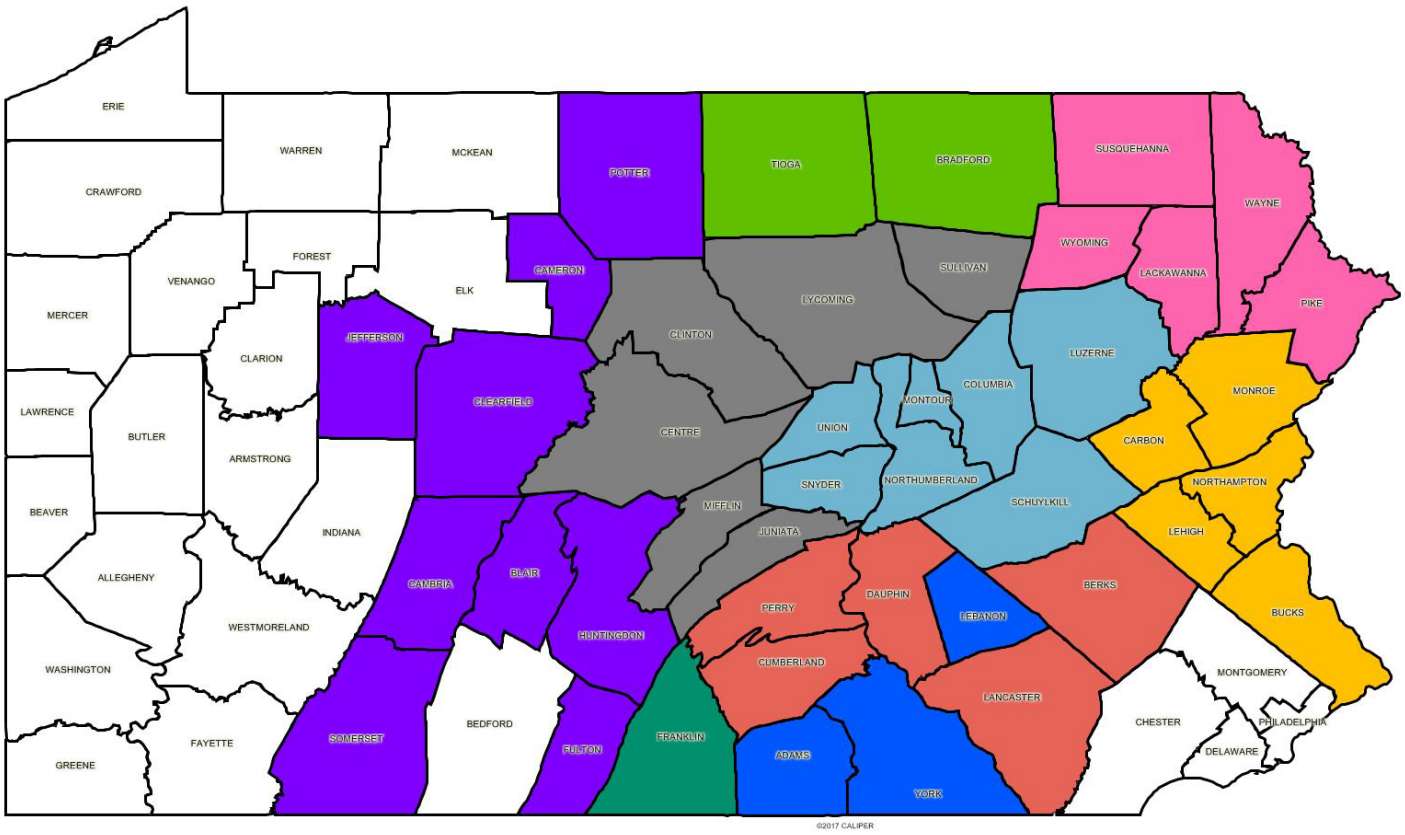
Classic Advantage (Rx)

- Monthly plan premium varies by region
- No deductible
- Offered with or without prescription drug coverage
- Supplemental benefits, such as dental, vision, hearing & fitness embedded into plan

Geisinger Gold HMO (H3954)

Classic Essential Rx | Classic Complete Rx | Classic Advantage (Rx)



010 – Midwest Region
Classic Essential Rx: $0
Classic Complete Rx: $38
Classic Advantage: $75
Classic Advantage Rx: $158

011 – Bradford, Tioga Region
Classic Essential Rx: 0
Classic Complete Rx: $38
Classic Advantage: $75
Classic Advantage Rx: $158

012 – Lackawanna, Pike, Susquehanna, Wayne, Wyoming Region
Classic Essential Rx: $0
Classic Complete Rx: $38
Classic Advantage: $35
Classic Advantage Rx: $125

013 – Midstate Region
Classic Essential Rx: $0
Classic Complete Rx: $38
Classic Advantage: $75
Classic Advantage Rx: $158

014 – Central Region
Classic Essential Rx: $0
Classic Complete Rx: $38
Classic Advantage: $90
Classic Advantage Rx: $183

015 – Bucks, Carbon, Lehigh, Monroe, Northampton Region
Classic Essential Rx: $0
Classic Complete Rx: $38
Classic Advantage: $30
Classic Advantage Rx: $135

016 – Franklin Region
Classic Essential Rx: $0
Classic Complete Rx: $38
Classic Advantage: $75
Classic Advantage Rx: $158

017 – Berks, Cumberland, Dauphin, Lancaster, Perry Region
Classic Essential Rx: $0
Classic Complete Rx: $38
Classic Advantage: $30
Classic Advantage Rx: $149

018 – Adams, Lebanon, York Region
Classic Essential Rx: $0
Classic Complete Rx: $38
Classic Advantage: $40
Classic Advantage Rx: $154

Note: 2019 benefits, premiums & cost-sharing are pending CMS approval as of 7/25/2018.

HMO	Classic Essential Rx	Classic Complete Rx	Classic Advantage (Rx)	
2018 Star Rating	4	4	4	
Premium	$0	$38	010 – $75/$158 011 – $75/$158 012 – $35/$125 013 – $75/$158 014 – $90/$183	015 – $30/$135 016 – $75/$158 017 – $30/$149 018 – $40/$154
Deductible	$0	$0	$0	
Out of Pocket Max	$6,700	$4,900	$3,400	
PCP	$10	$5	$0	
Physician Specialist	$40	$35	$20	
Inpatient Hospital - Acute	$225/day (days 1-6) $0/day (days 7-90)	$200/day (days 1-6) $0/day (days 7-90)	$175/day (days 1-6) $0/day (days 7-90)	
Inpatient Psychiatric Hospital	$225/day (days 1-6) $0/day (days 7-90)	$200/day (days 1-6) $0/day (days 7-90)	$175/day (days 1-6) $0/day (days 7-90)	
Skilled Nursing Facility	$0/day (days 1-20) $160/day (days 21-62) $0/day (days 63-100)	$0/day (days 1-20) $160/day (days 21-51) $0/day (days 52-100)	$0/day (days 1-20) $160/day (days 21-42) $0/day (days 43-100)	
Cardiac/Pulmonary Rehab	$0 per day	$0 per day	$0 per day	
Urgent Care (Waive if Admitted)	$40	$35	$20	
Emergency Care (Waive if Admitted)	$90	$90	$120	
Ground & Air Ambulance (Waived if Admitted)	$200	$200	$100	
Worldwide Coverage (Waive if Admitted)	Urgent Care: $40 Emergency Care: $90 Ground Ambulance: $200 Air Ambulance: $1,000 $100,000 benefit limit	Urgent Care: $35 Emergency Care: $90 Ground Ambulance: $200 Air Ambulance: $1,000 $100,000 benefit limit	Urgent Care: $20 Emergency Care: $120 Ground Ambulance: $100 Air Ambulance: $1,000 $100,000 benefit limit	
Home Health Services (includes related medical supplies)	$0	$0	$0	
Chiropractic Services (Original Medicare Benefit)	$20	$20	$20	
Podiatry (Original Medicare Benefits)	$40	$35	$20	
Podiatry - Routine Nail Trimming	$0 / 4 per year	$0 / 4 per year	$0 / 4 every year	
Occupational/Physical/ Speech Therapy	$40 per day	$35 per day	$20 per day	
Outpatient Lab & Other Outpatient Diagnostic Tests	$10 per day	$5 per day	$5 per day	
Outpatient X-Rays	$35 per day	$30 per day	$25 per day	
Outpatient Diagnostic Radiology: ultrasound, fluoroscopy, DEXA imaging	$35 per day	$30 per day	$25 per day	
Outpatient Diagnostic Radiology: MRI, CT, PET Scans, etc.	$225 per day	$225 per day	$150 per day	

Note: 2019 benefits, premiums & cost-sharing are pending CMS approval as of 7/25/18.

HMO	Classic Essential Rx	Classic Complete Rx	Classic Advantage (Rx)
Outpatient Standard Radiation Therapy	$35 per day	$30 per day	$25 per day
Outpatient Complex Radiation Therapy	$60 per day	$60 per day	$60 per day
Outpatient Surgery/ Services	$350	$245	$200
Outpatient Mental Health	Individual Session: $25 Group Session: $10	Individual Session: $25 Group Session: $10	Individual Session: $25 Group Session: $10
Part B Drugs	20%	20%	20%
Durable Medical Equipment (DME)	20%	20%	20%
Prosthetics and Related Supplies	20%	20%	20%
Diabetic Supplies **Preferred brand – OneTouch** (prior auth required for non-preferred brand supplies, more than 200 test strips per month, more than 1 glucometer every 2 years)	$0 - preferred brand glucometer (1 every 2 years); 20% - preferred brand supplies (test strips, lancets & lancet devices); 20% - non-preferred brand glucometers & supplies	$0 - preferred brand glucometer (1 every 2 years); 20% - preferred brand supplies (test strips, lancets & lancet devices); 20% - non-preferred brand glucometers & supplies	$0 - preferred brand glucometer (1 every 2 years); 0% - preferred brand supplies (test strips, lancets & lancet devices); 20% - non-preferred brand glucometers & supplies
Diabetic Supplies Therapeutic Shoes or Inserts	20%	20%	20%
Supplemental Preventive Health Svc - Annual Routine Physical Exams	$10	$5	$0
Supp Education/Health Mgmt Progs – Health Club	Not covered	$90 / every 3 months	$90 / every 3 months
Supp Education/Health Mgmt Progs - Nursing Hotline	$0	$0	$0
Dental Services (Preventive): Oral Exam with or without cleaning	Not covered	$0 / 2 per year	$0 / 2 per year
Dental Services (Preventive): Dental X-Rays	Not covered	$0 / 1 per year	$0 / 1 per year
Combined Preventive & Comprehensive Dental (Non-Medicare Covered)	Not covered	$500 benefit limit per year	$500 benefit limit per year
Comprehensive Dental (Original Medicare Covered Benefit only)	$40	$35	$20
Vision Exam (Medical): $0 for glaucoma screen - office visit copay may apply	$40	$35	$20
Routine Vision Exam	Not covered	$20 / 1 per year	$20 / 1 per year

Note: 2019 benefits, premiums & cost-sharing are pending CMS approval as of 7/25/18.

HMO	Classic Essential Rx	Classic Complete Rx	Classic Advantage (Rx)
Original Medicare-Covered Eyewear (Post-Cataract Surgery)	$0 (basic frames & lenses)	$0 (basic frames & lenses)	$0 (basic frames & lenses)
Routine Eyewear: (Non-Medicare Covered) Contact lenses, eyeglasses, lenses, frames	Not covered	$100 benefit limit per year	$200 benefit limit / every 2 years
Hearing Exams - Diagnostic Only	$40	$35	$20
Routine Hearing Exams	Not covered	$20 / 1 per year	$20 / 1 per year
Hearing Aids/Fitting for Hearing Aids	Not covered	$500 copay per ear, $3,000 benefit limit per ear, every 3 years	$500 copay per ear, $3,000 benefit limit per ear, every 3 years

Prescription Drug Coverage

HMO: Classic Essential Rx, Classic Complete Rx, Classic Advantage Rx			
Deductible	$0	$0	$0
	30-day retail supply	90-day retail supply	90-day mail order supply
Tier 1 Preferred Generics	$3	$7.50	$4.50
Tier 2 Non-preferred Generics	$20	$50	$30
Tier 3 Preferred Brand	$47	$117.50	$70.50
Tier 4 Non-preferred Brand	$100	$250	$150
Tier 5 Specialty	33%	Not available	Not available
Gap Coverage – Tier 1 Generics	$3	Not available	Not available

Note: 2019 benefits, premiums & cost-sharing are pending CMS approval as of 7/25/18.

Secure Rx

HMO SNP Plan

Secure Rx is a Special Needs Plan designed for individuals who are eligible for Medicare and receive **full** Medicaid coverage. It is available in 40 counties throughout the Gold service area. **The service area expansion does not apply to the Secure Rx plan.** Members must go to providers and hospitals within the plan's network. Members must obtain their covered routine dental services from an Avesis network provider.

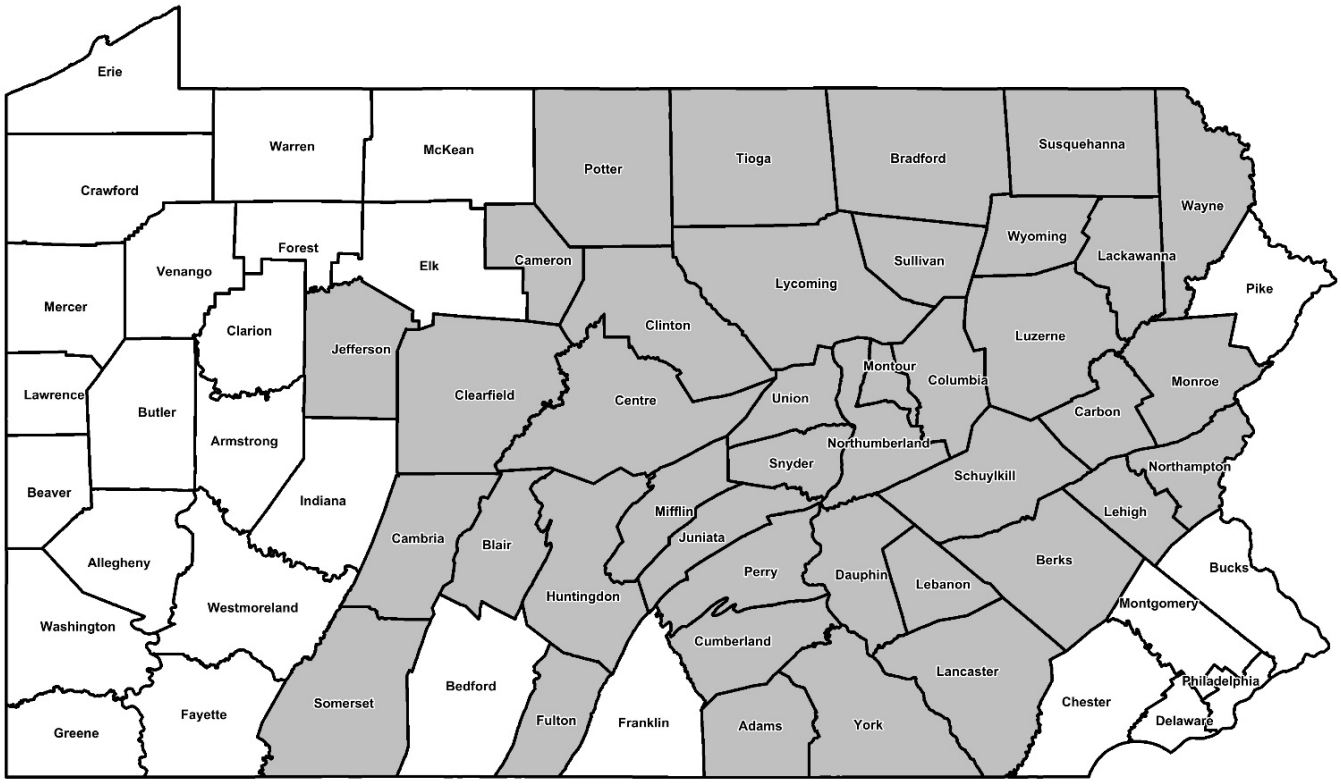
Please note: Pennsylvania Medicaid may require certain Secure Rx members to pay nominal Medicaid copayments when receiving covered services. State Medicaid copayment amounts will depend on the member's level of Medical Assistance.

Secure Rx

- $0 monthly plan premium across all regions (paid by PA Medicaid)
- $0 cost-sharing for all Medicare-covered services
  - Medicaid cost-sharing may apply
- Includes prescription drug coverage
  - Reduced cost-sharing
- Supplemental benefits, such as dental, vision, hearing & fitness embedded into plan
- Transportation benefit is reimbursement only with the use of any source (taxi, uber, Rabbit Transit, etc.)

Geisinger Gold HMO SNP (H3954)

Secure Rx



Secure Rx: $0*

*Part C (medical only). Premium and cost sharing is based on the level of Medicaid eligibility. $0 premium assumes full dual-eligibility.

Note: 2019 benefits, premiums & cost-sharing are pending CMS approval as of 7/25/18.

	Secure Rx (HMO SNP)
2018 Star Rating	4
Premium	$0
Deductible	$0 to member
Out of Pocket Max	$6,700
PCP	$0 to member
Physician Specialist	$0 to member
Inpatient Hospital - Acute	$0 to member
Inpatient Psychiatric Hospital	$0 to member
Skilled Nursing Facility	$0 to member
Cardiac/Pulmonary Rehab	$0 to member
Urgent Care	$0 to member
Emergency Care	$0 to member
Ambulance	$0 to member
Worldwide Coverage	$0 to member
Home Health Services (includes related medical supplies)	$0 to member
Chiropractic Services (Original Medicare Benefit)	$0 to member
Podiatry (Original Medicare Benefits)	$0 to member
Podiatry - Routine Nail Trimming	$0 to member
Occupational Therapy	$0 to member
Physical & Speech Therapy	$0 to member
Outpatient Lab & Other Outpatient Diagnostic Tests	$0 to member
Outpatient X-Rays	$0 to member
Outpatient Diagnostic Radiology: ultrasound, fluoroscopy, DEXA imaging	$0 to member
Outpatient Diagnostic Radiology: MRI, CT, PET Scans, etc.	$0 to member
Outpatient Standard Radiation Therapy	$0 to member
Outpatient Complex Radiation Therapy	$0 to member
Outpatient Surgery/Services	$0 to member
Outpatient Mental Health	$0 to member

Note: 2019 benefits, premiums & cost-sharing are pending CMS approval as of 7/25/18.

	Secure Rx (HMO SNP)
Part B Drugs	$0 to member
Durable Medical Equipment (DME)	$0 to member
Prosthetics and Related Supplies	$0 to member
Diabetic Supplies **Preferred brand - OneTouch**	$0 Preferred Brand Glucometer every 2 years; $0 test strips, lancets & non-preferred brand meters (prior auth required for non-preferred brand supplies, more than 200 test strips per month, more than 1 glucometer every 2 years)
Diabetic Supplies - Therapeutic Shoes or Inserts	$0 to member
Acupuncture & Other Alternative Therapies - Non-Medicare Covered	Not Covered
Supplemental Preventive Health Svc – Annual Routine Physical Exams	$0 to member
Supp Education/Health Mgmt Progs – Health Club	$120 per quarter
Supp Education/Health Mgmt Progs – Nursing Hotline	$0 to member
Dental Services: Preventive & Comprehensive (Non-Medicare Covered)	$0 to member; $3,000 benefit limit per year; includes simple fillings, simple extractions, dentures, crowns & root canals, 2 visits per year for exams, cleanings, fluoride treatments, x-rays
Comprehensive Dental (Original Medicare-Covered Benefit only)	$0 to member
Vision Exam (Medical): $0 for glaucoma screen - office visit copay may apply	$0 to member
Routine Vision Exam	$0 to member; 1 per year
Original Medicare-Covered Eyewear (Post-Cataract Surgery)	$0 to member
Routine Eyewear: (Non-Medicare Covered) Contact lenses, eyeglasses, lenses, frames	$0 to member $300 benefit limit every year
Hearing Exams - Diagnostic Only	$0 to member
Routine Hearing Exams	$0 to member; 1 per year
Hearing Aids/Fitting for Hearing Aids	$350 copay per ear, $3,000 benefit limit per ear, every 3 years
Personal Emergency Response Systems	$700 maximum benefit per year
Transportation (medical related)	$500 reimbursement allowance per year
Part D	Part D drugs covered with appropriate LIS cost-sharing & premium subsidies
Over-the-Counter Drugs	$50 allowance per month

Contact the Broker Service Unit at 866-488-6653 to confirm dual eligibility status.

Note: 2019 benefits, premiums & cost-sharing are pending CMS approval as of 7/25/18.

Preferred Complete Rx
Preferred Enhanced Rx
Preferred Advantage Rx

PPO Plans

Members have the freedom to choose any doctor or hospital who accepts Medicare and is willing to bill Geisinger. $0 deductible on all plans. Referrals are not required to see specialists (in or out-of-network). Covered services can be obtained from either in-network or out-of-network providers at the same cost-sharing (exceptions apply to Preferred Enhanced Rx). **Our service area is expanding to include Bucks, Franklin & Pike counties for 2019.**

Preferred Complete Rx

- $0 monthly plan premium across all regions
- Includes prescription drug coverage
- Supplemental benefits, such as dental, vision, hearing & fitness available through optional Gold Health+ package

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Preferred Enhanced Rx

- New PPO plan for 2019
- Moderate monthly plan premium across all regions
- Includes prescription drug coverage
- Supplemental benefits, such as dental, vision & fitness embedded into plan
    - Higher annual allowance amount with the use of in-network Avesis dental providers
    - Low annual fee with the use of in-network Silver & Fit fitness centers

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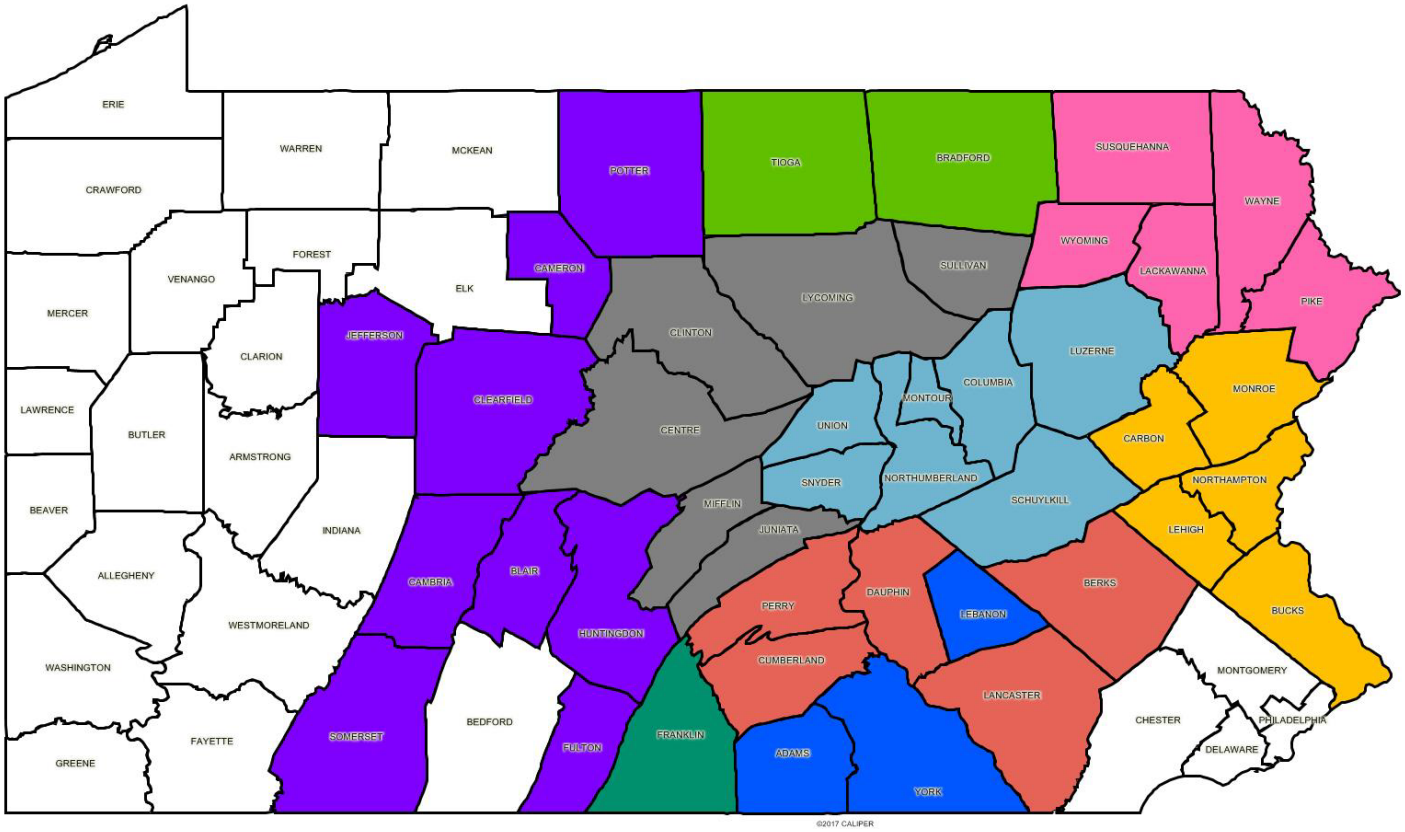
Preferred Advantage Rx

- Monthly plan premium varies by region
- Includes prescription drug coverage
- Supplemental benefits, such as dental, vision, hearing & fitness available through optional Gold Health+ package

Geisinger Gold PPO (H3924)

Preferred Complete Rx | Preferred Enhanced Rx | Preferred Advantage Rx



010 – Midwest Region
Preferred Complete Rx: $0
Preferred Enhanced Rx: $45
Preferred Advantage Rx: $112

011 – Bradford, Tioga Region
Preferred Complete Rx: $0
Preferred Enhanced Rx: $45
Preferred Advantage Rx: $112

012 – Lackawanna, Pike, Susquehanna, Wayne, Wyoming Region
Preferred Complete Rx: $0
Preferred Enhanced Rx: $45
Preferred Advantage Rx: $112

013 – Midstate Region
Preferred Complete Rx: $0
Preferred Enhanced Rx: $45
Preferred Advantage Rx: $112

014 – Central Region
Preferred Complete Rx: $0
Preferred Enhanced Rx: $45
Preferred Advantage Rx: $117

015 – Bucks, Carbon, Lehigh, Monroe, Northampton Region
Preferred Complete Rx: $0
Preferred Enhanced Rx: $45
Preferred Advantage Rx: $87

016 – Franklin Region
Preferred Complete Rx: $0
Preferred Enhanced Rx: $45
Preferred Advantage Rx: $112

017 – Berks, Cumberland, Dauphin, Lancaster, Perry Region
Preferred Complete Rx: $0
Preferred Enhanced Rx: $45
Preferred Advantage Rx: $87

018 – Adams, Lebanon, York Region
Preferred Complete Rx: $0
Preferred Enhanced Rx: $45
Preferred Advantage Rx: $87

Note: 2019 benefits, premiums & cost-sharing are pending CMS approval as of 7/25/18.

PPO	Preferred Complete Rx	Preferred Enhanced Rx	Preferred Advantage Rx	
2018 Star Rating	4	4	4	
Premium	$0	$45	010 - $112 011 - $112 012 - $112 013 - $112 014 - $117	015 - $87 016 - $112 017 - $87 018 - $87
Deductible	$0	$0	$0	
Out of Pocket Max	$6,700 (combined in & out)	$5,500 (combined in & out)	$4,000 (combined in & out)	
	in-network or out-of-network	**in-network or out-of-network**	**in-network or out-of-network**	
PCP	$15	$10	$5	
Physician Specialist	$40	$35	$25	
Inpatient Hospital – Acute	$225/day (days 1-6) $0/day (days 7-90)	$225/day (days 1-6) $0/day (days 7-90)	$200/day (days 1-6) $0/day (days 7-90)	
Inpatient Psychiatric Hospital	$225/day (days 1-6) $0/day (days 7-90)	$225/day (days 1-6) $0/day (days 7-90)	$200/day (days 1-6) $0/day (days 7-90)	
Skilled Nursing Facility	$0/day (days 1-20) $160/day (days 21-62) $0/day (days 63-100)	$0/day (days 1-20) $160/day (days 21-54) $0/day (days 55-100)	$0/day (days 1-20) $160/day (days 21-45) $0/day (days 46-100)	
Cardiac/Pulmonary Rehab	$0 per day	$0 per day	$0 per day	
Urgent Care (Waived if Admitted)	$40	$35	$25	
Emergency Care (Waive if Admitted)	$90	$90	$90	
Ground & Air Ambulance (Waive if Admitted)	$275	$275	$200	
Worldwide Coverage (Waive if Admitted)	Urgent Care: $40 Emergency Care: $90 Ground Ambulance: $275 Air Ambulance: $1,000 $100,000 benefit limit	Urgent Care: $35 Emergency Care: $90 Ground Ambulance: $275 Air Ambulance: $1,000 $100,000 benefit limit	Urgent Care: $25 Emergency Care: $90 Ground Ambulance: $200 Air Ambulance: $1,000 $100,000 benefit limit	
Home Health Services (includes related medical supplies)	$0	$0	$0	
Chiropractic Services (Original Medicare Benefit)	$20	$20	$20	
Podiatry (Original Medicare Benefits)	$40	$35	$25	
Podiatry - Routine Nail Trimming	$0 / 4 every year	$0 / 4 per year	$0 / 4 every year	
Occupational/Physical/ Speech Therapy	$40 per day	$35 per day	$25 per day	
Outpatient Lab & Other Outpatient Diagnostic Tests	$30 per day	$20 per day	$15 per day	
Outpatient X-Rays	$40 per day	$35 per day	$25 per day	
Outpatient Diagnostic Radiology: ultrasound, fluoroscopy, DEXA imaging	$40 per day	$35 per day	$25 per day	
Outpatient Diagnostic Radiology: MRI, CT, PET Scans, etc.	$275 per day	$265 per day	$200 per day	

Note: 2019 benefits, premiums & cost-sharing are pending CMS approval as of 7/25/18.

PPO	Preferred Complete Rx	Preferred Enhanced Rx		Preferred Advantage Rx
	in-network or out-of-network	in-network or out-of-network		in-network or out-of-network
Outpatient Standard Radiation Therapy	$40 per day	$35 per day		$25 per day
Outpatient Complex Radiation Therapy	$60 per day	$60 per day		$60 per day
Outpatient Surgery/ Services	$350	$275		$225
Outpatient Mental Health	Individual Session: $25 Group Session: $10	Individual Session: $25 Group Session: $10		Individual Session: $25 Group Session: $10
Part B Drugs	20%	20%		20%
Durable Medical Equipment (DME)	20%	20%		20%
Prosthetics and Related Supplies	20%	20%		20%
Diabetic Supplies **Preferred brand – OneTouch** (prior auth required for non-preferred brand supplies, more than 200 test strips per month, more than 1 glucometer every 2 years)	$0 - preferred brand glucometer (1 every 2 years); 20% - preferred brand supplies (test strips, lancets & lancet devices); 20% - non-preferred brand glucometers & supplies	$0 - preferred brand glucometer (1 every 2 years); 20% - preferred brand supplies (test strips, lancets & lancet devices); 20% - non-preferred brand glucometers & supplies		$0 - preferred brand glucometer (1 every 2 years); 20% - preferred brand supplies (test strips, lancets & lancet devices); 20% - non-preferred brand glucometers & supplies
Diabetic Supplies - Therapeutic Shoes or Inserts	20%	20%		20%
Supplemental Preventive Health Svc - Annual Routine Physical Exams	$15	$10		$5
Supp Education/Health Mgmt Progs - Health Club	Optional Health+	IN (Silver & Fit) $25 annual fee	OON 20% coinsurance	Optional Health+
Supp Education/Health Mgmt Progs - Nursing Hotline	$0	$0		$0
Dental Services (Preventive): Oral Exam with or without cleaning	Optional Health+	$0 / 2 per year		Optional Health+
Dental Services (Preventive): Dental X-Rays	Optional Health+	$0 / 2 per year		Optional Health+
Comprehensive Dental (Original Medicare-Covered Benefit only)	$40	$35		$25
Comprehensive Dental (Non-Medicare Covered)	Optional Health+	IN (Avesis) $650 benefit limit per year	OON $500 benefit limit per year	Optional Health+

Note: 2019 benefits, premiums & cost-sharing are pending CMS approval as of 7/25/18.

PPO	Preferred Complete Rx	Preferred Enhanced Rx	Preferred Advantage Rx
	in-network or out-of-network	in-network or out-of-network	in-network or out-of-network
Vision Exam (Medical): $0 for glaucoma screen - office visit copay may apply	$40	$35	$25
Routine Vision Exam	Optional Health+	$20 / 1 per year	Optional Health+
Original Medicare-Covered Eyewear (Post-Cataract Surgery)	$0 (basic frames & lenses)	$0 (basic frames & lenses)	$0 (basic frames & lenses)
Routine Eyewear: (Non-Medicare Covered) Contact lenses, eyeglasses, lenses, frames	Optional Health+	$250 benefit limit per year	Optional Health+
Hearing Exams - Diagnostic Only	$40	$35	$25
Routine Hearing Exams	Optional Health+	$20 / 1 per year	Optional Health+
Hearing Aids/Fitting for Hearing Aids	Optional Health+	Not covered	Optional Health+

Prescription Drug Coverage

PPO: Preferred Complete Rx, Preferred Enhanced Rx, Preferred Advantage Rx			
Deductible	$0	$0	$0
	30-day retail supply	90-day retail supply	90-day mail order supply
Tier 1 Preferred Generics	$3	$7.50	$4.50
Tier 2 Non-preferred Generics	$20	$50	$30
Tier 3 Preferred Brand	$47	$117.50	$70.50
Tier 4 Non-preferred Brand	$100	$250	$150
Tier 5 Specialty	33%	Not available	Not available
Gap Coverage – Tier 1 Generics	$3	Not available	Not available

Note: 2019 benefits, premiums & cost-sharing are pending CMS approval as of 7/25/18.

Geisinger Gold Health+

Optional Supplemental Benefits

Geisinger Gold Health+ is an optional supplemental benefits package available for purchase by members enrolled in Preferred Complete Rx and Preferred Advantage Rx. Benefits include: routine dental, routine vision exams and eyewear coverage, routine hearing exams and hearing aid coverage, and a fitness center allowance.

Geisinger Gold Health+

Preferred Complete Rx | Preferred Advantage Rx

Premium	• $38 per month
Dental	• $500 max benefit per year that includes: – 2 routine exams per year (with or without cleaning) – 1 set of x-rays per year (bitewing or panoramic) – Simple fillings, simple extractions, dentures, crowns & root canals – See any provider
Vision	• $0 copay – Preferred Advantage Rx • $20 copay – Preferred Complete Rx • 1 routine exam per year (includes refraction) • $100 hardware allowance per year (contacts, glasses, lenses, frames) • See any provider • Can be combined with GHP Accessories Program discounts
Hearing	• $20 copay • 1 routine exam per year • $500 hearing aid & fitting allowance per year • See any provider
Fitness	• $90 allowance per quarter • Access to facilities of your choice • Can be applied to any fitness service the facility offers (excludes food & beverage)

Guidelines

- Existing Geisinger Gold members can enroll in Health+ during AEP
- New Geisinger Gold members can purchase Health+ at enrollment and up to 30 days after their effective date
- Amounts spent on Health+ benefits do not count toward the plans annual out-of-pocket max
- Providers may bill Geisinger directly for routine eye exams, routine hearing exams, and dental benefits (members should ask providers if they are willing to bill Geisinger directly)
  - Members should submit receipts to Geisinger for reimbursement if providers are not willing to bill Geisinger directly
- Routine eyeglasses, eyeglass lenses, eyeglass frames, contact lenses, and hearing aids are reimbursement-only benefits

Note: 2019 benefits, premiums & cost-sharing are pending CMS approval as of 7/25/18.

- Two dental exams and cleanings can be done anytime during the year.
- Fitness membership benefits are primarily a reimbursement-only benefit
- The following fitness centers have agreements to bill Geisinger directly up to the plans monthly allowance
  - Danville Area Community Center (DACC)
  - Berwick YMCA
  - Bloomsburg YMCA
  - River Valley Regional YMCA (includes Williamsport, Eastern Lycoming, Jersey Shore, Bradford, and Tioga branches)
  - Lock Haven YMCA
  - Greater Scranton YMCA
  - Wilkes-Barre YMCA
  - Carbondale YMCA
- Non-commissionable plan

How Are Members Reimbursed

- Submit receipt(s) to Geisinger Health Plan, Attn: Claims 32-29, PO Box 8200, Danville, PA 17821
- Questions: call Geisinger Gold Customer Service Team at (800) 498-9731

Medicare Part D

Prescription Drug Coverage

All Geisinger Gold plans, except Classic Advantage (MA only) HMO are offered with $0 deductible prescription drug coverage. This benefit includes fixed copays for covered drugs in the initial coverage limit. Copays depend on the tier the drug is listed. Members will receive coverage through the gap for tier 1 generic drugs at $3 copays, a 63% discount on tier 2 generics, and a 75% discount on tier 3 and above brand drugs. Prescriptions must be filled at network pharmacies.

Geisinger Gold Rx plan members will only pay 1.5 x the copay for a 90-day supply in the initial coverage limit when they use CareSite mail order pharmacy.

Medicare Part D Prescription Drug Coverage

Individuals must enroll in a Geisinger Gold Medicare Advantage plan to elect Part D coverage

HMO: Classic Essential Rx, Classic Complete Rx, Classic Advantage Rx PPO: Preferred Complete Rx, Preferred Enhanced Rx, Preferred Advantage Rx			
Annual Deductible	$0		
Initial Coverage (total drug costs reach up to $3,820)	30-day retail copay: • Tier 1 - $3 • Tier 2 - $20 • Tier 3 - $47 • Tier 4 - $100 • Tier 5 – 33%	90-day retail copay: • Tier 1 - $7.50 • Tier 2 - $50 • Tier 3 - $117.50 • Tier 4 - $250 • Tier 5 – not available	90-day mail order copay: • Tier 1 - $4.50 • Tier 2 - $30 • Tier 3 - $70.50 • Tier 4 - $150 • Tier 5 – not available
Coverage Gap (total member drug costs reach $5,100)	Member pays: • $3 copay for Tier 1 generics • 37% of costs for Tier 2 generics • 25% of costs for Tier 3 & above brands*		
Catastrophic Coverage (after $5,100 is paid out-of-pocket)	Member pays the greater of: • 5% coinsurance; **or** • $3.40 copay for generics • $8.50 copay for brands		

*Although members only pay 25% of the cost for brand name drugs in the Coverage Gap, 75% of the price will count towards out-of-pocket spending.

HMO SNP: Secure Rx	
Annual Deductible	Member pays $0*
Initial Coverage	Depending on the level of Extra Help, member pays: • $0, $1.25, or $3.80 copays for generic drugs** • $0, $3.40, or $8.50 copays for brand drugs**
Coverage Gap	Depending on level of Extra Help, member pays: • $0, $1.25, or $3.80 copays for generic drugs** • $0, $3.40, or $8.50 copays for brand drugs**
Catastrophic Coverage	Member pays: • $0 copay for generic and brand drugs

*Generally, members in Secure Rx will not be subject to a deductible or the Coverage Gap

**Actual cost-sharing depends on the level of Extra Help (LIS) the member receives

Note: 2019 benefits, premiums & cost-sharing are pending CMS approval as of 7/25/18.

LIS (Low Income Subsidy)

What is LIS?

- Administered by the SSA and CMS for Part D Members.
- Provides financial assistance in paying for premiums, deductibles, copays & coinsurance.
- Eligibility is based on income and asset test using Federal Poverty Benchmark Guidelines.
- LIS may be incremental or full subsidy (25%, 50%, 75% or 100%).

Description	2019 Rx Deductible	2019 Rx Copayment	2019 Rx Catastrophic
No Drug	n/a	n/a	n/a
Premium Subsidy 0% (income ≥ 150% FPL)	$415	Varies based on plan options	$3.40 / $8.50*
Premium Subsidy 25% (income > 145% & < 150% FPL)	$85	15% coinsurance	$3.40 / $8.50
Premium Subsidy 50% (income >140% & < 145% FPL)	$85	15% coinsurance	$3.40 / $8.50
Premium Subsidy 75% (income > 135% & < 140% FPL)	$85	15% coinsurance	$3.40 / $8.50
Premium Subsidy 100% (income> 100% & < 135% FPL)	$85	15% coinsurance	$3.40 / $8.50
Premium Subsidy 100% FBDE (income> 100% & < 135% FPL)	$0	$3.40 / $8.50	$0
Premium Subsidy 100% FBDE (income ≤ 100% FPL)	$0	$1.25 / $3.80	$0
Full Dual Institutionalized 100%	$0	$0	$0

**Catastrophic coverage is the greater of 5% or the values shown*

2018 Federal Poverty Level Guidelines *(2019 FPL Guidelines to be released January 2018)*

Family Size	Annual Poverty Guideline (100% of the FPL)	Monthly Poverty Guideline (100% of the FPL)
1	$12,140	$1,011
2	$16,460	$1,371
3	$20,780	$1,731
4	$25,100	$2,091
5	$29,420	$2,451
6	$33,740	$2,811
7	$38,060	$3,171
8	$42,380	$3,531
***Note:** families with more than 8 persons, add $4,320 for each additional person*		

TrOOP (True-Out-Of-Pocket) Costs

- **What Counts Toward the TrOOP?**
  - Costs that the beneficiary spent on formulary drugs (or non-formulary drugs that have been granted an exception by the plan).
  - Costs paid by the beneficiary's family, a charity, or a State Pharmaceutical Assistance Program such as PACE/PACENET.
- **Costs that do not count toward the TrOOP**
  - Costs paid for non-formulary drugs (without prior approval).
  - Cost of drugs purchased outside the United States.
  - Costs paid for by other insurance.
  - Premiums paid to the Part D plan.
  - Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
  - Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
  - Payments made by the plan for your brand or generic drugs while in the Coverage Gap.

Geisinger CareSite Mail-Order Pharmacy

Mail order pharmacy is available to Gold member's through Geisinger CareSite. Generally, drugs provided through mail order are maintenance drugs that are taken on a regular basis, for chronic or long-term medical conditions. Drugs not available through the plan's mail order service are marked with "NM" on the formulary.

Providers may e-scribe directly to the Geisinger CareSite Pharmacy. Geisinger Gold's mail order service requires members to order at least an 84-day supply and no more than a 90-day supply of covered drugs. Prescriptions cannot be mailed without a valid form of payment on file. Geisinger CareSite ships to the following states: PA, NJ, NY, DE, OH, FL, IN and WI.

Members can enroll in Geisinger CareSite mail order pharmacy by calling 844-878-5562 or online at www.geisinger.org/pharmacy. Automatic refill is available upon request. Mail order is not mandatory for Gold member's.

Diabetic Supplies

- **Supplies covered under Part B:** glucometers, diabetic test strips, lancets, therapeutic shoes and inserts, and insulin pumps (DME)
- **Supplies covered under Part D:** insulin, diabetic pens and needles

Part D Late Enrollment Penalty (LEP)

- Individuals who have Medicare and don't enroll in a Part D plan when first eligible AND don't have other creditable drug coverage may pay a late enrollment penalty if they enroll in a drug plan later.
- Individuals who do not enroll in a Part D plan within 63 consecutive days or more from the end of their IEP for Part B, may have to pay a LEP (1% of the national base beneficiary premium for each full, uncovered month).
- Individuals enrolled in any of the following creditable drug coverage are exempt from paying a LEP:
  - Extra Help (LIS)
  - PACE/PACENET
  - Veterans Affairs program
  - TRICARE
  - FEHB program
  - Employer/Union group Part D plan

Medication Therapy Management (MTM) Program

- Service provided by pharmacists or other health care professionals to ensure prescribed drugs are appropriately used to optimize therapeutic outcomes and to reduce the risk of adverse effects and interactions.
- Individuals are automatically enrolled if they meet the following criteria:
  - Have at least 3 of the following conditions: diabetes, COPD, high blood pressure, high cholesterol, osteoporosis
  - Are taking 7 or more medications to treat the above chronic conditions, and
  - Have a total annual drug cost of $4,044 or more
- Members can also request to be included in the MTM Program.

Part B & Part D IRMAA

What is the Part B & Part D Income Related Monthly Adjustment Amount (IRMAA)?

- Higher income individuals will pay higher Part B ***(Standard Medicare Part B premium is $134 in 2018***) & Part D premiums.
- Part B & Part D IRMAA is based on income that is reported to the IRS.
- Additional amount is % based on national base beneficiary premium.
- Part B & Part D IRMAA are reviewed annually and collected by the Social Security Administration

**Part B IRMAA premiums may increase in 2019*

File individual tax return	File joint tax return	File married & separate tax return	*2018 Part B Monthly Premium Increase	2019 Part D Monthly Premium Increase
≤ $85,000	≤ $170,000	≤ $85,000	$0	$0
> $85,000 and ≤ $107,000	> $170,000 and ≤ $214,000	not applicable	$53.50	$13.00
> $107,000 and ≤ $133,500	> $214,000 and ≤ $267,000	not applicable	$133.90	$33.60
> $133,500 and ≤ $160,000	> $267,000 and ≤ $320,000	not applicable	$214.30	$54.20
> $160,000	> $320,000	> $85,000	$294.60	$74.80

2019 Part D IRMAA formula calculation

$$\text{IRMAA } 50\% = \$35.02 \times \frac{50\% - 25.5\%}{25.5\%} = \$33.64 \text{ (rounded to } \$33.60)$$

Individuals will pay monthly Part B & D premiums equal to 35%, 50%, 65%, or 80% of the total cost.

PPACA Prescription Drug Discount Program

What is the Manufacturer's Coverage Gap Discount program?

- As part of the Affordable Care Act, member cost share in the coverage gap is being reduced incrementally until 2020 when the member will have a 25% coinsurance in the coverage gap.
- Members who enter the coverage gap in 2019 will receive a discount at the pharmacy:
  - Brand Name Drugs – 70% discount (50% manufacturer paid & 20% Medicare Part D plan paid)
  - Generic Drugs – 63% discount (paid by Medicare Part D plan)

How is the Manufacturer's Coverage Gap Discount determined?

- To qualify, the drug must be a formulary drug or an approved exception or transition claim
- The drug must be on the CMS Approved Part D list of participating manufacturers
- The member must not be eligible for "extra help" (LIS)
- The claim must be partially or fully in the coverage gap

How is the Manufacturer's Coverage Gap Discount Calculated brand name drugs in the coverage gap?

- The claim discount is based on the negotiated price:
  - Member's coinsurance is 25% of ingredient cost + the dispensing fee

Example: Ingredient cost = $60.00
Dispensing fee = $2.00
$60 + $2 x .25 = $15.50

How to determine if a drug is on the Manufacturer's Coverage Gap Discount program?

- Is the plan Part D?
- Is the plan discount eligible?
  - Non-eligible plans: Retiree Drug Subsidy, MSP, Life Geisinger, P2P, SNP's
- Is member non-LIS?
- Is the drug a Part D covered drug?
- Is the Member in the coverage gap?
- Is the drug on the approved manufacturer list?
- Calculate discount

Do the same rules apply for the Generic Drug Discount program?

- Yes, the same rules apply for program eligibility
- However, instead of 70%, a discount of 63% is applied
- MAC (maximum allowable cost) Drugs – priced below AWP negotiated rates - the entire cost is eligible for discount

PACE and PACENET

What is PACE/PACENET Coverage?

- PA State Pharmaceutical Assistance Program (SPAP)
  - Offers low cost prescription medication to qualified PA residents
- Funded by PA Lottery Proceeds
- Costs member nothing to enroll
- Eligibility Requirements
  - Meet Income Limits (determined by prior year's income) and be age 65 or older
  - Must be a resident of PA for at least 90 days prior to enrollment
- Limited to 30-day supply (or 100 dosage units)
- Creditable coverage
- How to enroll in PACE/PACENET: Enroll online at https://pacecares.magellanhealth.com. Download applications and email them to papace@magellanhealth.com or fax them to (888) 656-0372. You may also call PACE/PACENET at (800) 225-7223.

PACE	*2017 Annual Income Limits	*2017 Monthly Income Limits	*2018 Cost Sharing (30-day supply)
Individuals	$14,500 or less	$1,208 or less	Generic drugs: $6
Married	$17,700 or less	$1,475 or less	Brand drugs: $9

PACENET	*2017 Annual Income Limits	*2017 Monthly Income Limits	*2018 Cost Sharing (30-day supply)
Individuals	$14,501 - $23,500	$1,208 - $1,958	Generic drugs: $8
Married	$17,701 - $31,500	$1,475 - $2,625	Brand drugs: $15

** Income limits and cost sharing may change for 2019*

- **PACE with no Part D coverage**
  - Members pay the PACE copays
- **PACE with Part D coverage**
  - PACE pays the monthly Part D premium to the plan for those plans that have an agreement with the state
  - Members pay the PACE copays
  - PACE covers costs of drugs over the PACE copay during the Part D deductible & gap phases

- **PACENET with no Part D coverage**
  - Members pay a monthly Part D premium at the pharmacy
  - Members pay the PACENET copays
- **PACENET with Part D coverage**
  - Members pay the monthly Part D premium to the plan
  - Members pay the PACENET copays
  - PACENET covers costs of drugs over the PACENET copay during the Part D deductible & gap phase
- **What is PACEPLUS?**
  - PACEPLUS is the program that represents PACE plus Medicare Part D
  - Medicare is the PRIMARY payer
  - MA-PD copay may be billed to PACE program by the pharmacy
  - Member pays the PACE copay
  - PACE coverage continues through the coverage gap
  - PACE program pays the MA-PD premium up to the Part D benchmark premium
  - PACE members will be billed by MA-PD for any premium over benchmark

PACE and PACENET FAQ

Q. If I have PACE or PACENET, why should I enroll in Geisinger Gold with Part D?

A. Many PACE or PACENET cardholders will save money by being enrolled in both PACE/PACENET and a Medicare Part D program at the same time because PACE/PACENET will help pay for prescriptions through the coverage gap. Plus, being enrolled in your health plan's Part D coverage helps the PACE and PACENET programs save money that can be used to help more Pennsylvanians.

Q. If I am enrolled in Geisinger Gold Part D, will I still use my PACE or PACENET card?

A. Yes, show both prescription cards at the pharmacy. This will let your pharmacist know to bill your Geisinger Gold Part D plan first, and bill PACE or PACENET second. It will also let your pharmacist know that you are entitled to all of the drugs that are available under PACE and PACENET.

Q. Will my co-payments be higher with PACE/PACENET and Geisinger Gold Part D coverage?

A. No, you will pay the lower of the two copayments. If your Geisinger Gold Part D co-payment is higher than what you were paying under PACE/PACENET, the PACE/PACENET program will pay the difference.

Q. I have not received any letter or other information from PACE or PACENET about how they will work with my Geisinger Gold Part D plan. Does that mean that I will not get any help from PACE or PACENET with Geisinger Gold Part D costs?

A. If you have not received information from the PACE/PACENET program, they may not know that you have a Geisinger Gold Part D plan. All PACE/PACENET members get help with their Part D deductibles, co-pays and costs during the donut hole. If you have any questions about how PACE/PACENET can work with your Geisinger Gold Part D plan, you should call Geisinger Gold at (800) 498-9731.

Q. What happens if my Geisinger Gold Part D Plan doesn't cover all of the drugs that PACE/PACENET covers?

A. The PACE/PACENET program will automatically pay for drugs that your Geisinger Gold Part D Plan won't cover, as long as these are drugs covered by PACE/PACENET.

Q. If I am in a Geisinger Gold plan without prescription drug coverage, do I have to change Geisinger Gold plans to enroll in Part D?

A. Enrollment in a Part D program is voluntary. Should you decide to choose part D coverage, and wish to maintain your same Geisinger Gold medical coverage, you must choose a Gold plan option with Part D coverage. Contact Geisinger Gold at (800) 498-9731 to find a plan that will work best for you.

Q. What should I do if I receive a bill from my Geisinger Gold Part D plan for the monthly premium?

A. If you are enrolled in a Geisinger Gold Part D plan, you may receive a bill for the monthly premium.

If you are a PACE member in a Geisinger Gold Part D plan that has signed a premium payment agreement with the program, you should not receive a monthly bill because PACE will pay the premium to the plan for you, as long as the monthly premium does not exceed Part D benchmark premium. You would receive a bill for any monthly premium in excess of the Part D benchmark premium.

All PACENET members who are in a Geisinger Gold Part D plan will receive a monthly premium bill for their Part D plan and are responsible for paying that premium directly to Geisinger Gold.

Q. Geisinger Gold Part D plans stop their coverage after you reach a certain dollar limit. This is referred to as the "donut hole" or coverage gap. How will this work if I have PACE/PACENET?

A. You will not experience a "donut hole", coverage gap or period of time when you have no prescription drug coverage. Instead, the PACE/PACENET program will fill in the gaps for covered medications.

Additional Resources

Important Contact Info

Medicare (eligibility status)	(800) MEDICARE
Social Security (Part A & B effective dates & LIS eligibility)	(800) 772-1213
Magellan Healthcare (behavioral health providers)	(888) 839-7972

Assistance finding eligible Prescription Assistance Programs

Partnership for Prescription Assistance (PPA): www.pparx.org
Needy Meds: www.needymeds.org
Rx Assist: www.rxassist.org

State Pharmaceutical Assistance Programs (SPAPs)

PACE/PACENET: 800-225-7723 or https://pacecares.magellanhealth.com
Special Pharmaceutical Benefits Program: 800-922-9384 or www.dhs.pa.gov/provider/healthcaremedicalassistance/specialpharmaceuticalbenefitsprogram/ • HIV/AIDS or Schizophrenia diagnosis

Patient Assistance Programs (PAPs)

Medicare LI NET: 800-783-1307 or www.humana.com/pharmacy/pharmacists/linet
PA Patient Assistance Program Clearinghouse: 800-955-0989 or https://pacecares.magellanhealth.com

Pharmaceutical Patient Assistance Programs

Lilly Cares: www.lillycares.com
GlaxoSmithKline: www.gskforyou.com
Novartis: https://www.pharma.us.novartis.com/our-products/patient-assistance
Merck Helps: www.merckhelps.com
Pfizer Rx Pathways: www.pfizerrxpathways.com
Sanofi Patient Connection: www.sanofipatientconnection.com
AstraZeneca Prescription Savings Program: www.astrazeneca-us.com/medicines/Affordability.html
Johnson & Johnson: www.jjpaf.org
Bristol-Myers Squibb: www.bms.com/patient-and-caregivers/get-help-paying-for-your-medicines.html

Election and Enrollment Period Guidance

Election Periods

Initial Enrollment Period for Part B (IEP):

Period when beneficiaries are first eligible for Medicare. They have a 7-month period to sign up for Medicare Part A and/or Part B. The period begins 3 months before, the month of, and ends 3 months after the month an individual turns 65. Beneficiaries who wait until the month they turn 65 or the 3 months after to enroll will have a delay in Part B coverage. Beneficiaries who have a disability will automatically be enrolled in Part B after receiving disability benefits for 24 months.

Initial Coverage Enrollment Period (ICEP):

Beneficiaries newly eligible for Medicare Advantage because they turned 65 or have been receiving disability benefits for 25 months can enroll in a Medicare Advantage plan 3 months before, the month of, and up to 3 months after they are entitled to both Medicare Parts A & B. Their effective date would be the 1st day of the month of entitlement to Medicare Part A & B, or the 1st of the month following the month the enrollment request is made, if after entitlement has occurred.

Annual Enrollment Period (AEP):

Occurs between October 15th and December 7th. Beneficiaries can enroll in or switch to a new Medicare Advantage plan. The coverage effective date is January 1st of the following year.

Open Enrollment Period (OEP):

Beginning 2019 Medicare Advantage plan members will have a one-time annual opportunity from January 1st to March 31st to disenroll from their current MA or MA-PD plan and switch to a different MA or MA-PD plan. Beneficiaries may also return to Original Medicare and purchase a Med Supp plan (subject to underwriting). Individuals can only purchase a PDP if they disenrolled from an MA-PD plan. Generally, the effective date will be the first of the month following receipt of the request. A request made in January will be effective February 1st and a request made in February will be effective March 1st.

Open Enrollment Period for Institutionalized Individuals (OEPI):

Individuals who move into, currently reside in, or move out of an institution (skilled nursing facility, rehabilitation hospital, etc.) have a continuous SEP to make unlimited MA enrollment requests as long as they are institutionalized. The SEP ends 2 months after the month the individual moves out of the institution. The effective date is the 1st of the month after receipt of enrollment request.

Year Round Sales Opportunities and Special Election Periods

Dual Eligible (Medicare & Medicaid):

Beneficiaries entitled to both Medicare Parts A & B and receive cost sharing assistance from Medicaid have an SEP that begins the month they become dually eligible and can be used once per calendar quarter, January through September. During the last quarter of the year, members may use the AEP to make an election. The effective date is the 1st of the following month after receipt of a completed election request.

Extra Help/Low Income Subsidy (LIS):

Beneficiaries who qualify for Extra Help/LIS have an SEP that begins the month the individual becomes eligible and can be used once per calendar quarter, January through September. During the last quarter of the year, members may use the AEP to make an election. The effective date occurs the 1st of the month after receipt of a completed election request.

Change in Residence:

Beneficiaries who moved outside the plans service area, moved and have new plan options available to them, or were recently released from incarceration have an SEP that begins:

- The month before the month of the move and continues for 2 full months, if individual notified the plan before the move. The effective date is the 1st of the following month and up to 3 months after the date of the move. (determined by enrollee)
- The month the plan is notified, plus 2 full months, if individual notified the plan after the move. The effective date is the 1st of the following month.

Medicare Part B SEP:

Beneficiaries who delay enrollment into Part B because they or a spouse are still working and receive health insurance through an employer will have an SEP to enroll in Part B upon retiring. The SEP begins the month after employment ends or the month after the group coverage ends (whichever is first) and ends 8 months after employment ends or the group coverage ends.

ICEP When Deferring Part B Enrollment:

If a beneficiary delays enrollment into Part B to a later time, their ICEP will occur only 3 months immediately prior to the month of their Part B effective date.

Employer/Union Group Health Plan (EGHP):

Beneficiaries who lost their EGHP coverage have an SEP that begins the month the EGHP allows for disenrollment and ends 2 months after employment ends or coverage ends, whichever comes first. The effective date is the 1st of the month and up to 2 months after the month coverage ends. (determined by enrollee)

State Pharmaceutical Assistance Program (PACE/PACENET):

Beneficiaries who are newly eligible or current SPAP eligibles have a one-time SEP each calendar year to switch plans. The effective date is the first of the following month after enrollment request is received.

SEP 65:

MA eligible beneficiaries who enroll in a MA plan during their IEP for Part B surrounding their 65th birthday have an SEP allowing them to disenroll from the MA plan and return to Original Medicare. The SEP begins the month the individual is enrolled for the first time in a MA plan and ends 12 months after the effective date of that MA plan.

Retroactive Notice of Medicare entitlement:

Beneficiaries who have not been provided the opportunity to elect a MA plan during their ICEP have an SEP that begins the month notice is received and ends 2 months after notice is received. The effective date is no earlier than the 1st of the month in which the notice is received.

Program of All-Inclusive Care for the Elderly (PACE):

Beneficiaries may disenroll from a MA plan at any time, in order to enroll in PACE. Beneficiaries who disenroll from PACE to enroll in a MA plan have an SEP that begins the 1st of the month following disenrollment from PACE and ends up to 2 months after the effective date of PACE disenrollment. The effective date depends on the situation.

Non-renewing Contracts:

Beneficiaries affected by plan or contract non-renewals and plan service area reductions that are effective January 1st of the contract year have an SEP to enroll in a new MA plan that begins December 8th and ends the last day in February the following year. The effective date is either January 1st, February 1st, or March 1st (depending when enrollment request is received).

Involuntary Loss of Creditable Coverage:

Beneficiaries who recently lost their creditable drug coverage through no fault of their own have an SEP that begins the month the individual is notified of the loss and ends 2 months after the notice is received or the loss occurs, whichever is later. The effective date is the 1st of the month following an enrollment request.

Loss of Dual Eligible Status:

MA eligible beneficiaries who are no longer eligible for cost sharing assistance through the Medicaid program have an SEP that begins the month notice is received and ends 2 additional months after notice is received. The effective date is the 1st of the month following an enrollment request.

Loss of Extra Help/LIS Eligibility:

Is the applicant no longer eligible for extra help paying for their Medicare prescription drugs? The effective date is the first of the following month in which the individual completes an enrollment request.

Trial Periods:

Beneficiaries who drop a Medicare Supplement plan to enroll in a MA plan for the first time may make a one-time election during the 12-month trial period after enrolling in the MA plan to disenroll and return to a Medicare Supplement plan. The SEP begins the month the individual enrolls in the MA plan and exists for 12 months. This re-enrollment would qualify for guaranteed issue.

One-on-One Appointment Checklist

Compliance Items (*agents must discuss all the following):*

- [ ] Introduce yourself by name (first and last) and company
- [ ] Wear your Health Plan ID badge
- [ ] Be sure the appointment starts within the designated window of time
- [ ] Courtesy call for tardiness: call the prospect if you're going to arrive later than the designated window of time
- [ ] Get a signed Scope of Appointment prior to the start of the meeting
- [ ] Explain that you work for a Medicare Advantage plan, and not Medicare or the Government
- [ ] Identify the types of products at the beginning of the meeting (HMO, PPO, SNP)
- [ ] Explain Original Medicare (Parts A, B, D) and how it works when enrolled in a MA plan (Part C)
- [ ] Explain that MA replaces OM (Simply put away your Medicare Red, White & Blue card and Geisinger Gold becomes your primary health insurance)
- [ ] Explain that member must continue to pay their Part B premium
- [ ] Be sure to ask questions to determine the prospects needs
- [ ] Define plan premium
- [ ] Explain IRMAA (Part B and D)
- [ ] Define deductible
- [ ] Define copayment
- [ ] Define coinsurance
- [ ] Explain the MOOP and how certain member cost sharing applies towards it
- [ ] Show and explain the medical and dental Provider Directories
- [ ] Explain provider network restrictions (HMO plans must use in-network providers)
- [ ] Explain that Gold plans do not have a deductible for Part D (coverage begins immediately)
- [ ] Explain the initial coverage limit of Part D (tiering and pricing)
- [ ] Explain the coverage gap of Part D (pricing)
- [ ] Explain catastrophic coverage of Part D (pricing)
- [ ] Show and explain the formulary (brand vs generic, tiers)
- [ ] Check prospects drugs in formulary
- [ ] When applicable, identify and explain drug restrictions (prior auth, transition policy, quantity limits, step therapy, non-mail order)
- [ ] Explain the exception process for medications not on the formulary
- [ ] Explain the need to use network pharmacies

- [ ] Explain the Geisinger CareSite mail order pharmacy (tiering and pricing)
- [ ] Explain when to enroll, disenroll, and/or change plans
- [ ] Show and explain Star Ratings sheet and reference the source

Compliance Items for SNP Prospects (*all the above, plus):*

- [ ] Explain SNP eligibility requirements
- [ ] Explain any changes in eligibility may lead to disenrollment
- [ ] Explain that Secure members will have $0 cost sharing for all medical benefits, but they may see nominal Medicaid copays depending on their level of Medical Assistance
- [ ] Explain that the cost of covered drugs depends on their level of LIS

Plan Materials

- [ ] Be sure you have all necessary Gold marketing materials at meeting
- [ ] Provide only CMS approved materials
- [ ] Do not show materials for other products (Life, Disability, Annuities, etc.)

Presenter Conduct

- [ ] Avoid high pressure and/or scare tactics
- [ ] Avoid cross-selling
- [ ] Do not provide incorrect competitor info
- [ ] Do not engage in discriminatory marketing practices
- [ ] Avoid making absolute statements unless it referenced by a source

Gifts

- [ ] Any gifts offered must be a combined value of $15 or less (never indicate a gift will be offered for enrolling in our plan)

Best Practices *(not required Compliance items)*

- [ ] Discuss that individuals who have PACE/PACENET or LIS will pay lower plan premiums
- [ ] Remind Secure Rx members that they need to show both their Gold card and Access card for services

Scope of Appointment Basics

When is the Scope of Appointment form required?

The scope of appointment form is required under the following circumstances:

- When conducting marketing activities for new or existing member's, in-person or telephonically, a scope of appointment form must be signed or agreed to prior to the appointment taking place.

If a beneficiary requested to discuss another product (e.g. MA during a PDP appointment) during their appointment, is the agent/broker required to complete a new Scope of Appointment documentation form?

- A new Scope of Appointment form is required if the beneficiary has requested to discuss another product type during the appointment. However, a new appointment is not required. The additional product can be discussed as soon as the beneficiary request is documented.

Should the Scope of Appointment form be completed prior to the appointment?

- The Scope of Appointment form should be completed by the beneficiary and returned prior to the appointment.
- If it is not feasible for the Scope of Appointment form to be executed prior to the appointment, an agent may have the beneficiary sign the form at the beginning of the marketing appointment.

How should the Scope of Appointment form be documented?

- CMS-approved Scope of Appointment form (either model or non-model)
- CMS-approved oral/recording Script of the Sales Appointment Confirmation
- CMS-approved business reply card
- Organizations are allowed to use various means for appropriate documentation (e.g. fax, email etc.)

Is the Scope of Appointment form required at sales events?

- Sales events do not require documentation of beneficiary agreement because they are not personal/individual appointments.
- The scope of products that will be discussed during a sales event must be indicated on all event advertising materials.
- Beneficiaries are not required to complete and sign the Scope of Appointment form prior to participating at a sales event.
- Beneficiaries may sign a Scope of Appointment form at a group sales presentation for a follow-up appointment. (The follow-up appointment does not need to be held 48 hours later; it may be held at the venue immediately following the sales presentation)

How do I Process/Submit a Scope of Appointment to Geisinger Gold?

- Signed Scope of Appointment forms must be submitted with each application.
- If a Scope of Appointment form is not submitted with an application please explain why (phone enrollment, group meeting, etc.) using the fax cover sheet available on the Marketing Portal.

See the next page for the model Scope of Appointment Form that can be copied and used

Scope of Sales Appointment Confirmation Form

Geisinger Gold

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss.
(Refer to page 2 for product type descriptions)

- ☐ **Stand-alone Medicare Prescription Drug Plans (Part D)**
- ☐ **Medicare Advantage Plans (Part C) and Cost Plans**
- ☐ **Dental/Vision/Hearing Products**
- ☐ **Hospital Indemnity Products**
- ☐ **Medicare Supplement (Medigap) Products**

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan.

Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:	
Signature	Signature Date
If you are the authorized representative, please sign above and print below:	
Representative's Name	Relationship to Beneficiary

To be completed by Agent:	
Agent Name	Agent Phone
Beneficiary Name	Beneficiary Phone (optional)
Beneficiary Address (optional)	
Initial Method of Contact (indicate here if beneficiary was a walk-in)	
Plan(s) the agent represented during the meeting	
Agent's Signature	Date Appointment Completed
Plan Use Only:	
Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting:	

*Scope of Appointment documentation is subject to CMS record retention requirements *

Stand-alone Medicare Prescription Drug Plans (Part D)
Medicare Prescription Drug Plan (PDP) — A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, and some Medicare Private-Fee-for-Service Plans.
Medicare Advantage Plans (Part C) and Cost Plans
Medicare Health Maintenance Organization (HMO) — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).
Medicare Preferred Provider Organization (PPO) Plan — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.
Medicare Private Fee-For-Service (PFFS) Plan — A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you – not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.
Medicare Point of Service (POS) Plan — A type of Medicare Advantage Plan available in a local or regional area which combines the best feature of an HMO with an out-of-network benefit. Like the HMO, members are required to designate an in-network physician to be the primary health care provider. You can use doctors, hospital, and providers outside of the network for an additional cost.
Medicare Special Needs Plan (SNP) — A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.
Medicare Cost Plan — In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.
Dental/Vision/Hearing Products
Plans offering additional benefits for consumers who are looking to cover needs for dental, vision or hearing. These plans are not affiliated or connected to Medicare.
Hospital Indemnity Products
Plans offering additional benefits: payable to consumers based upon their medical utilization; sometimes used to defray copay/coinsurance. These plans are not affiliated or connected to Medicare.
Medicare Supplement (Medigap) Products
Plans offering a supplemental policy to fill "gaps" in Original Medicare coverage. A Medigap policy typically pays some or all of the deductible and coinsurance amounts applicable to Medicare-covered services, and sometimes covers items and services that are not covered by Medicare, such as care outside of the country. These plans are not affiliated or connected to Medicare.

Geisinger Gold Medicare Advantage HMO, PPO, and HMO 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 annual contract renewal.

Geisinger Health Plan

Accessories Program

With the Accessories Program, you can get discounts on everyday health-related items, as well as tools to help you stay fit. Save money on products and services including:

- Fitness centers
- Amusement park admissions
- Child safety products
- Vision services
- Chiropractic care
- Massage therapy
- Acupuncture

Find more information online

All details about how to take advantage of these discounts can be found at GeisingerHealthPlan.com. Log in (registration required), go to the "Health and Wellness" drop-down menu and click "Local discounts."

Geisinger Health Plan may refer collectively to Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted.

HPM50jb Accessories Flyer Dev 4-18

Geisinger

Gold