Introduction to Summary of Benefits

You have choices about how to get your Medicare benefits. One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government. Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Geisinger Gold Preferred Rx (PPO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Geisinger Gold Preferred Rx (PPO)** covers and what you pay. If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov. If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About **Geisinger Gold Preferred Rx (PPO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print. This document may be available in a non-English language. For additional information, call us at (800) 498-9731.

Things to Know About Geisinger Gold Preferred Rx (PPO)

Hours of Operation

From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time.

From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time.

Geisinger Gold Preferred Rx (PPO) Phone Numbers and Website

If you are a member of this plan, call toll-free (800) 419-1376

If you are not a member of this plan, call toll-free (800) 419-1376

Our website: http://www.MeridianGeisingerGold.com

Who can join?

To join **Geisinger Gold Preferred Rx (PPO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in New Jersey: Monmouth and Ocean.

Which doctors, hospitals, and pharmacies can I use?

Geisinger Gold Preferred Rx (PPO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. You can see our plan's provider and pharmacy directory at our website (http://www.MeridianGeisingerGold.com). Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers - and *more*.
Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less.
Our plan members also get *more than what is* covered by Original Medicare. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, http://www.MeridianGeisingerGold.com. Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

If you have any questions about this plan's benefits or costs, please contact Geisinger Gold for details.

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Benefit	Geisinger Gold Preferred Rx (PPO)
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
How much is the monthly premium?	$109 per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	This plan does not have a deductible.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $6,700 for services you receive from in-network providers. • $10,000 for services you receive from any provider. • Your limit for services received from in-network providers will count toward this limit. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply. *Geisinger Gold Medicare Advantage HMO, PPO, HMO POS, HMO SNP, and MSA plans are offered by Geisinger Health Plan/Geisinger Quality Options, Inc., health plans with a Medicare contract. Continued enrollment in Geisinger Gold depends on annual contract renewal.*
COVERED MEDICAL AND HOSPITAL BENEFITS NOTE:	**SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION.** **SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.**
Acupuncture and Other Alternative Therapies	Not covered
Ambulance[1]	• In-network: $200 copay • Out-of-network: $200 copay If you are admitted to the hospital, you do not have to pay for the ambulance services.
Chiropractic Care	• Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • In-network: $20 copay • Out-of-network: 20% of the cost

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Dental Services[1]	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • In-network: $25 copay • Out-of-network: $30 copay Preventive dental services: • Cleaning (for up to 1 every six months): • In-network: You pay nothing • Out-of-network: 20% of the cost Dental x-ray(s) (for up to 1 every year): • In-network: You pay nothing • Out-of-network: 20% of the cost Oral exam (for up to 1 every six months): • In-network: You pay nothing • Out-of-network: 20% of the cost
Diabetes Supplies and Services[1]	Diabetes monitoring supplies: • In-network: You pay nothing • Out-of-network: 0-25% of the cost, depending on the supply Diabetes self-management training: • In-network: You pay nothing • Out-of-network: $30 copay Therapeutic shoes or inserts: • In-network: You pay nothing • Out-of-network: 0-25% of the cost, depending on the supply
Diagnostic Tests, Lab and Radiology Services, and X-Rays[1]	Diagnostic radiology services (such as MRIs, CT scans): • In-network: 20-30% of the cost, depending on the service • Out-of-network: 20-35% of the cost, depending on the service Diagnostic tests and procedures: • In-network: 20% of the cost • Out-of-network: 20% of the cost Lab services: • In-network: $10 copay • Out-of-network: 20% of the cost Outpatient x-rays: • In-network: $25 copay • Out-of-network: 20% of the cost Therapeutic radiology services (such as radiation treatment for cancer): • In-network: 20% of the cost • Out-of-network: 30% of the cost

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Doctor's Office Visits	Primary care physician visit: • In-network: $10 copay • Out-of-network: $15 copay Specialist visit: • In-network: $25 copay • Out-of-network: $30 copay
Durable Medical Equipment (wheelchairs, oxygen, etc.)[1]	• In-network: 20% of the cost • Out-of-network: 20% of the cost
Emergency Care	• $65 copay If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.
Foot Care (podiatry services)	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: $25 copay • Out-of-network: $30 copay Routine foot care (for up to 4 visit(s) every year): • In-network: You pay nothing • Out-of-network: $30 copay
Hearing Services	Exam to diagnose and treat hearing and balance issues: • In-network: $25 copay • Out-of-network: $30 copay Routine hearing exam (for up to 1 every year): • In-network: $25 copay • Out-of-network: $30 copay Hearing aid fitting/evaluation (for up to 1 every three years): • In-network: You pay nothing • Out-of-network: $30 copay Hearing aid: • In-network: You pay nothing • Out-of-network: You pay nothing Our plan pays up to $1,000 every three years for hearing aids from any provider.
Home Health Care[1]	• In-network: You pay nothing • Out-of-network: 20% of the cost

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Mental Health Care[1]	Inpatient visit: • Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. • Our plan covers 90 days for an inpatient hospital stay. • Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. • In-network: • $210 copay per day for days 1 through 7 • You pay nothing per day for days 8 through 90 • Out-of-network: 20% of the cost per stay Outpatient group therapy visit: • In-network: $10 copay • Out-of-network: 20% of the cost Outpatient individual therapy visit: • In-network: $25 copay • Out-of-network: 20% of the cost
Outpatient Rehabilitation[1]	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): • In-network: $10 copay • Out-of-network: 20% of the cost Occupational therapy visit: • In-network: $25 copay • Out-of-network: 20% of the cost Physical therapy and speech and language therapy visit: • In-network: $25 copay • Out-of-network: 20% of the cost
Outpatient Substance Abuse[1]	Group therapy visit: • In-network: $10 copay • Out-of-network: 20% of the cost Individual therapy visit: • In-network: $25 copay • Out-of-network: 20% of the cost
Outpatient Surgery[1]	Ambulatory surgical center: • In-network: $250 copay • Out-of-network: 20% of the cost Outpatient hospital: • In-network: $250 copay • Out-of-network: 20% of the cost

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Over-the-Counter Items	Not Covered
Prosthetic Devices (braces, artificial limbs, etc.)[1]	Prosthetic devices: • In-network: 20% of the cost • Out-of-network: 20% of the cost Related medical supplies: • In-network: 20% of the cost • Out-of-network: 20% of the cost
Renal Dialysis[1,2]	• In-network: 20% of the cost • Out-of-network: 25% of the cost
Transportation	Not covered
Urgent Care	• $25 copay If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for urgent care. See the "Inpatient Hospital Care" section of this booklet for other costs.
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: $0-25 copay, depending on the service • Out-of-network: $30 copay Routine eye exam (for up to 1 every year): • In-network: $25 copay • Out-of-network: $30 copay Contact lenses: • In-network: You pay nothing • Out-of-network: You pay nothing Eyeglasses (frames and lenses): • In-network: You pay nothing • Out-of-network: You pay nothing Eyeglasses frames: • In-network: You pay nothing • Out-of-network: You pay nothing Eyeglasses lenses: • In-network: You pay nothing • Out-of-network: You pay nothing Eyeglasses or contact lenses after cataract surgery: • In-network: You pay nothing • Out-of-network: 20% of the cost Our plan pays up to $200 every two years for eyewear from any provider.

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Preventive Care	• In-network: You pay nothing • Out-of-network: $30 copay Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colonoscopy • Colorectal cancer screenings • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.
INPATIENT CARE	
Inpatient Hospital Care[1]	Our plan covers an unlimited number of days for an inpatient hospital stay. In-network: • $225 copay per day for days 1 through 8 • You pay nothing per day for days 9 through 90 • You pay nothing per day for days 91 and beyond Out-of-network: • 20% of the cost per stay
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.

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Skilled Nursing Facility (SNF)[1]	Our plan covers up to 100 days in a SNF. • In-network: $0 copay per day for days 1 through 20 $156 copay per day for days 21 through 63 $0 copay per day for days 64 through 100 • Out-of-network: 20% of the cost per stay
PRESCRIPTION DRUG BENEFITS **How much do I pay?**	For Part B drugs such as chemotherapy drugs[1]: • In-network: 20% of the cost • Out-of-network: 25% of the cost Other Part B drugs[1]: • In-network: 20% of the cost • Out-of-network: 25% of the cost
Initial Coverage	• You pay the following until your total yearly drug costs reach $2,960. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies. **Standard Retail Cost-Sharing** **Tier** / **One-month supply** Tier 1 (Preferred Generic) — $3 copay Tier 2 (Non-Preferred Generic) — $18 copay Tier 3 (Preferred Brand) — $39 copay Tier 4 (Non-Preferred Brand) — $85 copay Tier 5 (Specialty Tier) — 33% of the cost **Standard Mail Order Cost-Sharing** **Tier** / **Three-month supply** Tier 1 (Preferred Generic) — $9 copay Tier 2 (Non-Preferred Generic) — $54 copay Tier 3 (Preferred Brand) — $117 copay Tier 4 (Non-Preferred Brand) — $255 copay • If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

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Coverage Gap	• Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $2,960. • After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 65% of the plan's cost for covered generic drugs until your costs total $4,700, which is the end of the coverage gap. Not everyone will enter the coverage gap. • Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you. **Standard Retail Cost-Sharing** **Tier** / **Drugs Covered** Tier 1 (Preferred Generic) / All **Standard Mail Order Cost-Sharing** **Tier** / **Drugs Covered** Tier 1 (Preferred Generic) / All
Catastrophic Coverage	• After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,700, you pay the greater of: • 5% of the cost, or $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copayment for all other drugs.