2024
Summary of Benefits

Geisinger Gold Preferred Enhanced Rx (PPO)

H3924, Plan 062 S22

Jan. 1 – Dec. 31, 2024

H3924_23264_14_M Accepted 9/26/23

Geisinger Gold Preferred Enhanced Rx (PPO) is a Medicare Advantage PPO plan (PPO stands for Preferred Provider Organization) with a Medicare contract. Enrollment in the Plan depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call Member Services at 1-800-498-9731 (TTY 711 or 1-800-654-5984) and request the *Evidence of Coverage* or access it online at www.geisingergold.com.

Call us with any questions. From Oct. 1 to Dec. 7: Daily, 8 a.m. to 8 p.m. From Dec. 8 to Sept. 30: Weekdays, 8 a.m. to 8 p.m. If you're a member, great! Call toll-free 800-498-9731. If you're not a member, we'd love to have you join us. Call toll-free 855-589-1423. TTY users call 711. Or visit our website: geisingergold.com.

To join Geisinger Gold Preferred Enhanced Rx (PPO), you must be entiled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes these counties in Pennsylvania: Adams, Berks, Bucks, Cameron, Chester, Franklin, Fulton, Jefferson, Lancaster, Lebanon, Lehigh, Northampton, Potter, Somerset, Tioga, and York.

Geisinger Gold Preferred Enhanced Rx (PPO) has a network of doctors, hospitals, pharmacies, and other providers that can be found on our website at www.geisingergold.com. Except in emergency situations, if you use providers that are not in our network, the plan may not pay for these services.

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 https://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1800-633-4227), 7 days a week, 24 hours a day. TTY users should call 1-877-486-2048.

	Geisinger Gold Preferred Enhanced Rx (PPO)
Monthly Plan Premium *(includes both medical and drugs)*	$64
Deductible	No deductible for medical.
Maximum out-of-pocket amount *(does not include Part D prescription drugs)*	From network providers: $7,550 From network and out-of-network providers combined: $7,550
Inpatient Hospital coverage*	**In-Network** $325 copayment for each Medicare-covered hospital stay. $0 copayment for additional Medicare-covered days. **Out-of-Network** $325 copayment for each Medicare-covered hospital stay. Cost-sharing will not exceed $975 annually for Medicare-covered inpatient hospital care In and Out of network combined.
Outpatient Hospital coverage*	
Outpatient hospital services	**In-Network** $0 - $305 copayment **Out-of-Network** $0 - $305 copayment
Outpatient hospital observation services	**In-Network** $0 - $305 copayment per day **Out-of-Network** $0 - $305 copayment
Ambulatory Surgical Center (ASC)*	**In-Network** $0 - $305 copayment **Out-of-Network** $0 - $305 copayment

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	Geisinger Gold Preferred Enhanced Rx (PPO)
Doctor Visits	
Primary Care Providers	**In-Network** $0 copayment **Out-of-Network** $0 copayment
Specialists	**In-Network** $35 copayment **Out-of-Network** $35 copayment
Preventive Care (e.g., flu vaccine, diabetic screenings)	**In-Network** $0 copayment **Out-of-Network** $0 copayment
Emergency care	$100 copayment Copayment is waived if you are admitted to a hospital within 3 days for the same condition.
Urgently needed services	$35 copayment Copayment is waived if you are admitted to a hospital within 3 days for the same condition.
Diagnostic Services/Labs/Imaging*	
Diagnostic tests and procedures	**In-Network** $10 copayment **Out-of-Network** $10 copayment
Lab services	**In-Network** $10 copayment **Out-of-Network** $10 copayment

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Diagnostic radiology services (e.g. MRI, CAT Scan)	**In-Network** $35 - $235 copayment **Out-of-Network** $35 - $235 copayment
Outpatient X-rays	**In-Network** $35 copayment **Out-of-Network** $35 copayment
Therapeutic Radiology	**In-Network** $35 - $60 copayment **Out-of-Network** $35 - $60 copayment
Hearing services	
Exam to diagnose and treat hearing and balance issues	**In-Network** $35 copayment **Out-of-Network** $35 copayment
Routine hearing exam	**In-Network** $20 copayment **Out-of-Network** $20 copayment Limited to 1 visit(s) every year In and Out of Network combined.
Fitting-evaluation(s) for hearing aids	**In-Network** $0 copayment **Out-of-Network** $20 copayment

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Dental Services	Up to a $1,000 combined annual allowance every year for all additional in-network preventive and comprehensive dental services.
Preventive dental services	
○ Oral Exams	**In-Network** $0 copayment **Out-of-Network** $0 copayment Limited to 2 oral exam(s) every year combined In and Out of Network
○ Prophylaxis (Cleaning)	**In-Network** $0 copayment **Out-of-Network** $0 copayment Limited to 2 cleaning(s) every year combined In and Out of Network
○ Dental X-Rays	**In-Network** $0 copayment **Out-of-Network** $0 copayment Limited to 1 x-ray(s) every year combined In and Out of Network
Comprehensive dental services*	
○ Restorative Services	**In-Network** $0 copayment **Out-of-Network** $0 copayment
○ Periodontics	**In-Network** $0 copayment **Out-of-Network** $0 copayment

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○ Endodontics	**In-Network** $0 copayment **Out-of-Network** $0 copayment
○ Extractions	**In-Network** $0 copayment **Out-of-Network** $0 copayment
○ Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services	**In-Network** $0 copayment **Out-of-Network** $0 copayment
Vision care	
Exam to diagnose and treat diseases and conditions of the eye	**In-Network** $0 - $35 copayment **Out-of-Network** $0 - $35 copayment
For people with diabetes, screening for diabetic retinopathy is covered once per year.	**In-Network** $0 - $35 copayment **Out-of-Network** $0 - $35 copayment
Eyewear after cataract surgery	**In-Network** $0 copayment **Out-of-Network** $0 copayment
Glaucoma screening	**In-Network** $0 copayment **Out-of-Network** $0 copayment

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Routine eye exam	**In-Network** $20 copayment **Out-of-Network** $20 copayment Limited to 1 visit(s) every year In and Out of Network combined.
Mental Health Services*	
Inpatient visit	**In-Network** $325 copayment for each Medicare-covered hospital stay. $0 copayment for an additional 60 lifetime reserve days. **Out-of-Network** $325 copayment for each Medicare-covered hospital stay. Cost-sharing will not exceed $975 annually for Medicare-covered care In and Out of Network combined.
Outpatient group therapy visit	**In-Network** $5 copayment **Out-of-Network** $5 copayment
Outpatient individual therapy visit	**In-Network** $10 copayment **Out-of-Network** $10 copayment
Skilled nursing facility*	**In-Network** $0 copayment each day for days 1 to 20, $160 copayment each day for days 21 to 68, and $0 copayment each day for days 69 to 100 for Medicare-covered skilled nursing facility care. **Out-of-Network** $0 copayment each day for days 1 to 20, $160 copayment each day for days 21 to 68, and $0 copayment each day for days 69 to 100 for Medicare-covered skilled nursing facility care.

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Physical Therapy*	**In-Network** $35 copayment **Out-of-Network** $35 copayment
Ambulance services	
Ground Ambulance	**In-Network** $275 copayment (waived if admitted) **Out-of-Network** $275 copayment (waived if admitted)
Air Ambulance	**In-Network** $275 copayment **Out-of-Network** $275 copayment
Transportation Services	**In-Network** Not covered **Out-of-Network** Not covered
Medicare Part B prescription drugs*	
Chemotherapy/Radiation drugs	**In-Network** 0% - 20% coinsurance **Out-of-Network** 0% - 20% coinsurance
Other Part B drugs	**In-Network** 0% - 20% coinsurance; Insulin capped at $35 **Out-of-Network** 0% - 20% coinsurance; Insulin capped at $35

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Additional Benefits

	Geisinger Gold Preferred Enhanced Rx (PPO)
Annual routine physical exam	**In-Network** $0 copayment **Out-of-Network** $0 copayment
Chiropractic services We cover only manual manipulation of the spine to correct subluxation	**In-Network** $15 copayment **Out-of-Network** $15 copayment
Diabetic monitoring supplies*	**In-Network** 0% - 20% coinsurance **Out-of-Network** 0% - 20% coinsurance
Diabetic therapeutic shoes or inserts*	**In-Network** 20% coinsurance **Out-of-Network** 20% coinsurance
Durable medical equipment (DME) and related supplies*	**In-Network** 20% coinsurance **Out-of-Network** 20% coinsurance
Fitness program	**In-Network** $25 annual fee to Silver & Fit facilities. **Out-of-Network** 20% coinsurance

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Flexible spending card for dental, vision, and hearing devices	$450 allowance per year.
Home health agency care*	**In-Network** $0 copayment **Out-of-Network** $0 copayment
Hospice	$0 copayment
Nursing hotline	**In-Network** $0 copayment **Out-of-Network** $0 copayment
Opioid treatment program services*	**In-Network** 20% coinsurance **Out-of-Network** 20% coinsurance
Outpatient diagnostic tests and therapeutic services and supplies*	**In-Network** $35 - $60 copayment **Out-of-Network** $35 - $60 copayment

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Outpatient rehabilitation services* Services provided by an occupational therapist	**In-Network** $35 copayment **Out-of-Network** $35 copayment
Outpatient substance abuse services*	**In-Network** $10 copayment for each Medicare-covered Individual Session. $5 copayment for each Medicare-covered Group Session. **Out-of-Network** $5 - $10 copayment
Over-the-Counter Items (OTC)	**In-Network** $0 copayment You are eligible for a $35 annual allowance every month to be used toward the purchase of over-the-counter (OTC) health and wellness products. **Out-of-Network** $0 copayment
Partial hospitalization services for mental health*	**In-Network** $55 copayment per day **Out-of-Network** $55 copayment per day
Podiatry services	**In-Network** $35 copayment **Out-of-Network** $35 copayment

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Additional routine foot care	**In-Network** $0 copayment **Out-of-Network** $0 copayment Limited to 4 visit(s) every year combined in and out-of-network
Prosthetic devices and related supplies*	**In-Network** 20% coinsurance **Out-of-Network** 20% coinsurance
Pulmonary rehabilitation services	**In-Network** $15 copayment **Out-of-Network** $15 copayment
Services to treat kidney disease Dialysis Services	**In-Network** 10% - 20% coinsurance **Out-of-Network** 20% coinsurance
Welcome to Medicare preventive visit	**In-Network** $0 copayment **Out-of-Network** $0 copayment
Worldwide Emergency Coverage	$100 copayment
Worldwide emergency transportation	$275 - $1,000 copayment
Worldwide urgent care coverage	$35 copayment

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Prescription Drug Coverage	Geisinger Gold Preferred Enhanced Rx (PPO)
Stage 1: Annual Prescription Deductible	
Deductible	This plan has no deductible for Part D drugs, this payment stage doesn't apply.
Stage 2: Initial Coverage (after you pay your deductible, if applicable) until total yearly drug costs reach $5,030	
Standard Retail cost-sharing (30-day supply)	
Tier 1 (Preferred Generic)	$0 copayment
Tier 2 (Generic)	$5 copayment
Tier 3 (Preferred Brand)	$47 copayment
Tier 4 (Non-Preferred Drug)	$100 copayment
Tier 5 (Specialty Tier)	33% coinsurance
Tier 6 (Vaccines Tier)	$0 copayment
Mail-order cost sharing (up to a 100-day supply)	
Tier 1 (Preferred Generic)	$0 copayment
Tier 2 (Generic)	$0 copayment
Tier 3 (Preferred Brand)	$70.50 copayment
Tier 4 (Non-Preferred Drug)	$150 copayment
Tier 5 (Specialty Tier)	Not Available
Tier 6 (Vaccines Tier)	$0 copayment

Prescription Drug Coverage	Geisinger Gold Preferred Enhanced Rx (PPO)
Stage 3: Coverage Gap	
	After your total drug costs (including what our plan has paid and what you have paid) reach $5,030, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap.
Stage 4: Catastrophic Coverage	
	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $8,000, you pay nothing.

You won’t pay more than $35 for a one-month supply, $70 for tier 3 and $70 for tier 4 for a two-month supply, and $87.50 for tier 3 and $87.50 for tier 4 for a three-month supply of each covered insulin product regardless of the cost-sharing tier.

Cost-sharing may differ based on point-of-service (mail-order, retail, Long Term Care (LTC)), home infusion, whether the pharmacy is in our standard network, or whether the prescription is a short-term (30-day supply) or long term (100-day supply).

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-800-498-9731.

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit www.geisingergold.com or call 1-800-498-9731 to view a copy of the EOC.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2025.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.