2014 GEISINGER GOLD

Quick Reference Guide

GEISINGER GOLD®

*For Agent Use Only. Please note: Benefits and premiums for 2014 are pending CMS approval as of 8/8/13 and are subject to change.

PA_Quick_2014

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.

Web address: To log into the Geisinger Gold broker portal, please visit www.geisingergold.com/broker
Please see page 70 of this manual for more information

Contacts and Office Locations:

Broker Service Unit (dual eligibility status, supplies, product, commission questions)	(866) 488-6653
Enrollment (fax) *	**(570) 214-1552** or (570) 271-5970
Enrollment Address **	Geisinger Health Plan Attn: Enrollment 32-29 PO Box 8200 Danville, PA 17821-8200
Compliance	(570) 214-9281
Employer Groups Retiree Sales	(570) 490-1622
Customer Service / Claims	(800) 498-9731
Claims Address	Geisinger Health Plan Attn: Claims 32-29 PO Box 8200 Danville, PA 17821-8200
Marketing	(570) 271-8135
Member Grievances	(800) 498-9731
Provider Network Management	(800) 498-9731
Medicare & LIS Eligibility	(800) MEDICARE

***Enrollment forms must be faxed within 24 hours of the prospective member's signature.**

** Applications must be submitted with both Part A and Part B effective dates.

About Geisinger Health Plan and Geisinger Gold

Introduced in 1994, Geisinger Gold serves more than 65,000 members in 40 counties throughout Pennsylvania. We currently contract with more than 96 area hospitals and more than 40,000 doctors and more than 3,000 pharmacies in Pennsylvania to provide medical care for our members. Geisinger Gold 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 allowable commissions per CMS each month and competitive commissions on Medicare Supplements.

You'll have access to our dedicated broker service unit and highly acclaimed member service.

With programs like Geisinger MeetingAssist (client seminar support). Built exclusively for our valued brokers, this program allows you to enroll your existing clients in Geisinger Gold quickly and compliantly. You'll be able to write more business while leaving the service to us. Plus, a Geisinger Gold broker relationship manager will help you maximize your sales.

A new Marketing Portal is available for our agents and brokers to do everything from ordering collateral to developing marketing campaigns. New agent/broker focused direct mail/print ads have been developed to support our MSA and other Medicare Advantage products.

A new, easier to use agent-friendly training portal has been deployed that operates on all operating systems.

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

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

Table of Contents

Geisinger Gold 2014 Plan Offerings

Please note: 2014 Benefits, premiums & cost-sharing are pending CMS approval as of 8/8/13.

Classic 1, 3 and 4 (HMO) (Pages 10-15)

Geisinger Gold Classic Plans are traditional Health Maintenance Organization plans where members must select a primary care physician and go to providers and hospitals within the plans network. Referrals to see specialists are required however they are flexible and last up to 180 days.

Classic Plus (HMO-POS) (Pages 10-15)

Geisinger Gold Classic Plus (HMO-POS) is a Medicare Advantage HMO plan with a Point of Service option allowing members to seek care outside the network. Members are encouraged to choose a PCP in-network, but it is not required. Referrals are not required in or out-of-network, but cost-sharing may be higher out-of-network.

Preferred 1, 2 and 3 (PPO) (Pages 18-22)

Geisinger Gold Preferred Plans are Medicare Advantage Preferred Provider Organization plans where members are not required to select a primary care physician and no referrals are required to see specialists (in or out-of-network). Members will pay less if they go to providers and hospitals within the network. Out-of-network costs are limited by a combined in-network/ out-of-network out of pocket maximum.

Secure 1 (HMO SNP) (Pages 24-26)

Geisinger Gold Secure 1 (HMO) is a Special Needs Plan designed for people who are eligible for Medicare Part A, enrolled in Part B and receive **full** Medicaid coverage. Special Needs Plans can be sold any time of the year.

Reserve (MSA) (Pages 28-29)

A Medicare Advantage health insurance plan that links to a personal Medical Savings Account to help pay for medical expenses. The health plan deposits $1,500 directly into a personal Medical Savings Account. Geisinger Gold Reserve has a deductible of $3,000, but no monthly premium. Members can go to any doctor or hospital that accepts Medicare and is willing to bill the health plan. No referrals are necessary. Once the deductible amount is met, the health plan pays for medical expenses in full. Members cannot make deposits directly into the account however they can use the money to pay for qualified medical expenses. Expenses

incurred for Medicare-covered services go toward the annual deductible. If any money is left in the MSA at the end of the calendar year, it will roll over to the following year. This plan does not include prescription drug coverage. Members may add prescription drug coverage by joining a stand-alone Medicare prescription drug plan at a separate cost.

Medicare Part D Rx Drug Coverage (All HMO, HMO-POS & PPO) (Pages 32-36)

All plans except Reserve (MSA) and Secure 1 (HMO SNP) are available with optional $0 Deductible prescription drug coverage. This benefit includes no deductible and fixed, predictable copays in the initial coverage level and cost sharing up to the coverage gap. Members will receive coverage through the gap for tier 1 generic drugs at a $3 copay, 52.5% brand drug and 28% generic drug coverage (for all generics not covered on our tier 1), as well as the Geisinger Gold contracted rates (discount from retail) on prescriptions while in the coverage gap.

Additional Benefits (All HMO, HMO-POS & PPO)

All plans except Reserve (MSA) feature the following additional benefits:

- World-wide emergency room & urgent care
- Coverage routine vision exams, eyewear, hearing exams and hearing aids, preventive dental services, foot care, $0 annual wellness visits and 24 hour nurse line
- Silver Sneakers® fitness center membership

Medicare Covered Preventive Service *(cost to member: $0)*

Abdominal Aortic Aneurysm Screening	Bone Mass Measurement
Cardiovascular Screening	Pap Text and Pelvic Exam
Colorectal Screening	Diabetes Screening
Immunizations	HIV Screening
Mammography	Medical Nutritional Therapy
Annual Wellness Visit	Welcome to Medicare Exams
Prostate Screening	Smoking Cessation
Glaucoma Screening	Cardiovascular Disease Risk Reduction
Screening & Counseling Alcohol Misuse	Depression Screening
Screening for Sexually Transmitted Infections	Obesity Screening & Therapy

All plans require members to continue to pay their monthly Medicare Part B premium, live in the service area and not have ESRD.

2014 Geisinger Gold Premiums by County (WITH Rx)																	
	Preferred 1 PPO	Preferred 1 PPO	Preferred 2 PPO	Preferred 2 PPO	Preferred 2 PPO	Preferred 3 PPO	Classic 1 HMO	Classic 1 HMO	Classic 1 HMO	Classic 1 HMO	Classic 3 HMO	Classic 4 HMO	Classic Plus HMO-POS	Classic Plus HMO-POS	Classic Plus HMO-POS	Classic Plus HMO-POS	Secure 1 HMO SNP
County	H3924-003	H3924-023	H3924-046	H3924-048	H3924-052	H3924-054	H3954-021	H3954-027	H3954-033	H3954-137	H3954-100	H3954-139	H3954-141	H3954-151	H3954-153	H3954-155	H3954-097
Adams		$81.00		$65.00					$127.00		$41.00			$105.00			n/a
Berks		$81.00		$65.00			$156.00				$41.00		$110.00				n/a
Blair	$157.00			$65.00			$156.00				$41.00		$110.00				n/a
Cambria	$157.00			$65.00			$156.00				$41.00		$110.00				n/a
Cameron	$157.00			$65.00					$127.00		$41.00			$105.00			n/a
Carbon					$66.00	$148.00				$88.00		$45.00				$100.00	n/a
Centre	$157.00		$60.00						$127.00		$41.00			$105.00			n/a
Clearfield	$157.00		$60.00						$127.00		$41.00			$105.00			n/a
Clinton	$157.00		$60.00				$156.00				$41.00		$110.00				n/a
Columbia	$157.00		$60.00				$156.00				$41.00		$110.00				n/a
Cumberland	$157.00		$60.00						$127.00		$41.00			$105.00			n/a
Dauphin		$81.00	$60.00						$127.00		$41.00			$105.00			n/a
Fulton	$157.00		$60.00				$156.00				$41.00		$110.00				n/a
Huntingdon	$157.00		$60.00				$156.00				$41.00		$110.00				n/a
Jefferson	$157.00			$65.00					$127.00		$41.00			$105.00			n/a
Juniata	$157.00			$65.00			$156.00				$41.00		$110.00				n/a
Lackawanna	$157.00		$60.00					$143.00			$41.00				$100.00		n/a
Lancaster		$81.00	$60.00						$127.00		$41.00			$105.00			n/a
Lebanon		$81.00	$60.00						$127.00		$41.00			$105.00			n/a
Lehigh					$66.00	$148.00				$88.00		$45.00				$100.00	n/a
Luzerne	$157.00		$60.00					$143.00			$41.00				$100.00		n/a
Lycoming	$157.00		$60.00				$156.00				$41.00		$110.00				n/a
Mifflin	$157.00			$65.00					$127.00		$41.00			$105.00			n/a
Monroe	$157.00			$65.00			$156.00				$41.00		$110.00				n/a
Montour	$157.00		$60.00				$156.00				$41.00		$110.00				n/a
Northampton					$66.00	$148.00				$88.00		$45.00				$100.00	n/a
Northumberland	$157.00		$60.00				$156.00				$41.00		$110.00				n/a
Perry	$157.00			$65.00					$127.00		$41.00			$105.00			n/a
Pike	$157.00			$65.00			$156.00				$41.00		$110.00				n/a
Potter	$157.00			$65.00			$156.00				$41.00		$110.00				n/a
Schuylkill	$157.00			$65.00			$156.00				$41.00		$110.00				n/a
Snyder	$157.00		$60.00				$156.00				$41.00		$110.00				n/a
Somerset	$157.00			$65.00			$156.00				$41.00		$110.00				n/a
Sullivan	$157.00		$60.00						$127.00		$41.00			$105.00			n/a
Susquehanna	$157.00			$65.00					$127.00		$41.00			$105.00			n/a
Tioga	$157.00		$60.00				$156.00				$41.00		$110.00				n/a
Union	$157.00		$60.00				$156.00				$41.00		$110.00				n/a
Wayne	$157.00			$65.00			$156.00				$41.00		$110.00				n/a
Wyoming	$157.00		$60.00				$156.00				$41.00		$110.00				n/a
York		$81.00	$60.00						$127.00		$41.00			$105.00			n/a

Note: 2014 benefits, premiums & cost-sharing are pending CMS approval as of 8/8/13.

2014 Geisinger Gold Premiums by County (WITHOUT Rx)																	
	Preferred 1 PPO	Preferred 1 PPO	Preferred 2 PPO	Preferred 2 PPO	Preferred 2 PPO	Preferred 3 PPO	Classic 1 HMO	Classic 1 HMO	Classic 1 HMO	Classic 1 HMO	Classic 3 HMO	Classic 4 HMO	Classic Plus HMO-POS	Classic Plus HMO-POS	Classic Plus HMO-POS	Classic Plus HMO-POS	Secure 1 HMO SNP
County	H3924-001	H3924-021	H3924-045	H3924-047	H3924-051	H3924-053	H3954-003	H3954-005	H3954-007	H3954-136	H3954-098	H3954-138	H3954-140	H3954-150	H3954-152	H3954-154	H3954-097
Adams		$40.00		$28.00					$92.00		$0.00			$60.00			$0.00
Berks		$40.00		$28.00			$118.00				$0.00		$70.00				$0.00
Blair	$105.00			$28.00			$118.00				$0.00		$70.00				$0.00
Cambria	$105.00			$28.00			$118.00				$0.00		$70.00				$0.00
Cameron	$105.00			$28.00					$92.00		$0.00			$60.00			$0.00
Carbon					$31.00	$96.00				$50.00		$0.00				$60.00	$0.00
Centre	$105.00		$25.00						$92.00		$0.00			$60.00			$0.00
Clearfield	$105.00		$25.00						$92.00		$0.00			$60.00			$0.00
Clinton	$105.00		$25.00				$118.00				$0.00		$70.00				$0.00
Columbia	$105.00		$25.00				$118.00				$0.00		$70.00				$0.00
Cumberland	$105.00		$25.00						$92.00		$0.00			$60.00			$0.00
Dauphin		$40.00	$25.00						$92.00		$0.00			$60.00			$0.00
Fulton	$105.00		$25.00				$118.00				$0.00		$70.00				$0.00
Huntingdon	$105.00		$25.00				$118.00				$0.00		$70.00				$0.00
Jefferson	$105.00			$28.00					$92.00		$0.00			$60.00			$0.00
Juniata	$105.00			$28.00			$118.00				$0.00		$70.00				$0.00
Lackawanna	$105.00		$25.00					$98.00			$0.00				$60.00		$0.00
Lancaster		$40.00	$25.00						$92.00		$0.00			$60.00			$0.00
Lebanon		$40.00	$25.00						$92.00		$0.00			$60.00			$0.00
Lehigh					$31.00	$96.00				$50.00		$0.00				$60.00	$0.00
Luzerne	$105.00		$25.00					$98.00			$0.00				$60.00		$0.00
Lycoming	$105.00		$25.00				$118.00				$0.00		$70.00				$0.00
Mifflin	$105.00			$28.00					$92.00		$0.00			$60.00			$0.00
Monroe	$105.00			$28.00			$118.00				$0.00		$70.00				$0.00
Montour	$105.00		$25.00				$118.00				$0.00		$70.00				$0.00
Northampton					$31.00	$96.00				$50.00		$0.00				$60.00	$0.00
Northumberland	$105.00		$25.00				$118.00				$0.00		$70.00				$0.00
Perry	$105.00			$28.00					$92.00		$0.00			$60.00			$0.00
Pike	$105.00			$28.00			$118.00				$0.00		$70.00				$0.00
Potter	$105.00			$28.00			$118.00				$0.00		$70.00				$0.00
Schuylkill	$105.00			$28.00			$118.00				$0.00		$70.00				$0.00
Snyder	$105.00		$25.00				$118.00				$0.00		$70.00				$0.00
Somerset	$105.00			$28.00			$118.00				$0.00		$70.00				$0.00
Sullivan	$105.00		$25.00						$92.00		$0.00			$60.00			$0.00
Susquehanna	$105.00			$28.00					$92.00		$0.00			$60.00			$0.00
Tioga	$105.00		$25.00				$118.00				$0.00		$70.00				$0.00
Union	$105.00		$25.00				$118.00				$0.00		$70.00				$0.00
Wayne	$105.00			$28.00			$118.00				$0.00		$70.00				$0.00
Wyoming	$105.00		$25.00				$118.00				$0.00		$70.00				$0.00
York		$40.00	$25.00						$92.00		$0.00			$60.00			$0.00

Note: 2014 benefits, premiums & cost-sharing are pending CMS approval as of 8/8/13.

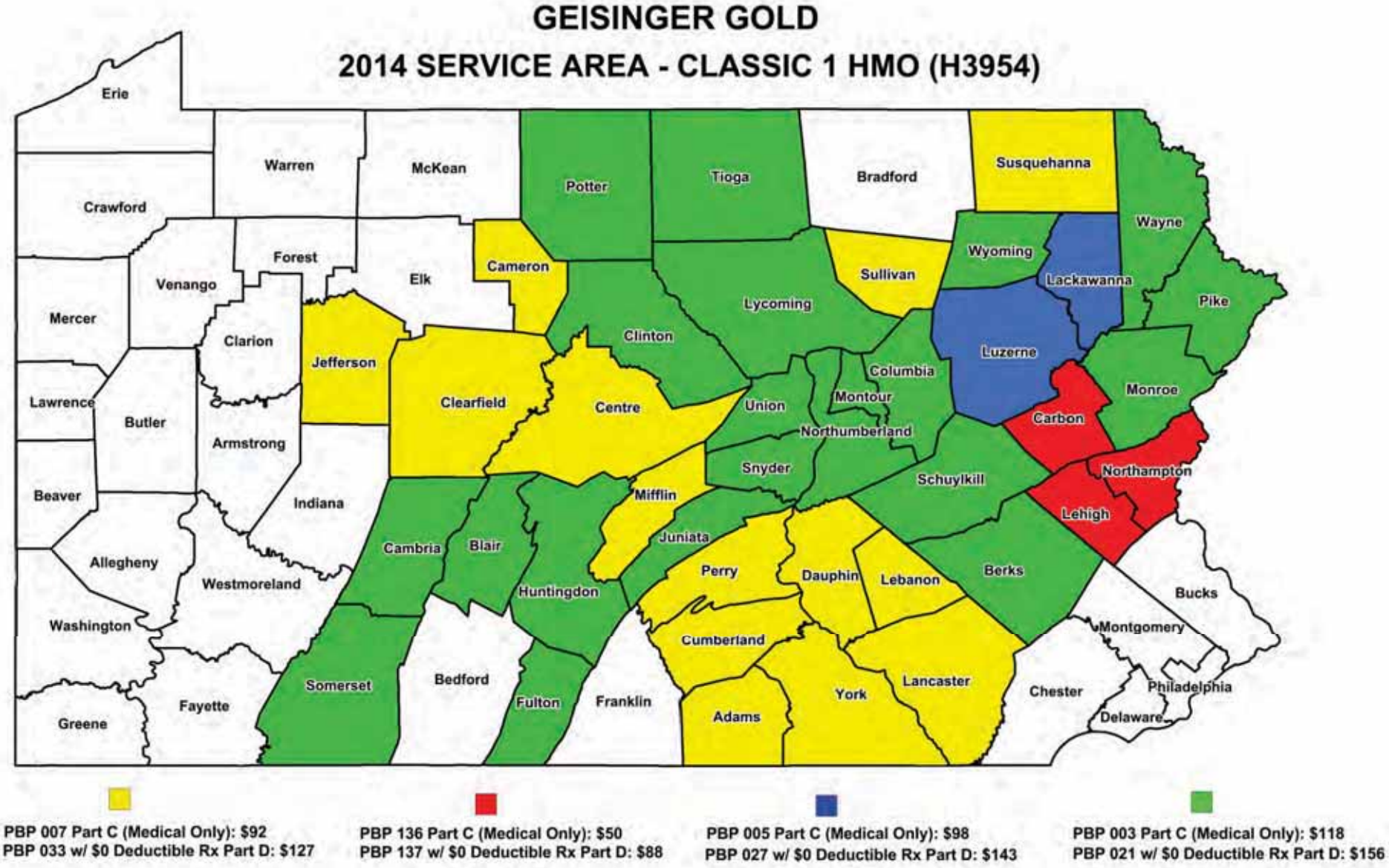
Classic HMO

BENEFIT DESCRIPTION	CLASSIC 1 (HMO)	CLASSIC 3 (HMO)	CLASSIC 4 (HMO)	CLASSIC PLUS (HMO-POS)	
	In-Network	In-Network	In-Network	In-Network	Out-of-Network
Plan Premium	see map	see map	see map	see map	
Plan Deductible	$0	$1,300	$1,600	$0	$0
Plan Out-of-Pocket Maximum	$2,800	$2,250	$2,250	$4,300	None
PCP/SCP (includes annual routine physical)	$10/$20	$10/$25	$10/$25	$10/$25	$15/$30
Physical, Speech & Occupational Therapy Services	$10 per day	$25 per day	$25 per day	$10 per day	20%
Chiropractic Services (Original Medicare Benefit)	$20	$20	$20	$20	20%
Podiatry (Original Medicare Benefit)/Routine Nail Trimming	$20/$0 - 4 per year	$25/$0 - 4 per year	$25/$0 - 4 per year	$20/$0 - 4 per year	20%/20% - 4 per year
Inpatient Hospital - Acute/Rehab	$100 per day (days 1-5) $0 per day (days 6-90)	Deductible Applies; Maximum OOP of $790	Deductible Applies; Maximum OOP of $750	$125 per day (days 1-5) $0 per day (days 6-90)	20%
Inpatient Psychiatric Hospital	$100 per day (days 1-5)	Deductible Applies; Maximum OOP of $790	Deductible Applies; Maximum OOP of $750	$125 per day (days 1-5) $0 per day (days 6-90)	20%
Skilled Nursing Facility	$50 per day (days 1-20) $75 per day (days 21-44) $0 per day (days 45-100) (no prior hospital stay required)	Deductible Applies; Maximum OOP of $1,000	Deductible Applies; Maximum OOP of $1,000	$25 per day (days 1-20) $70 per day (days 21-77) $0 per day (days 78-100) (no prior hospital stay required)	20%
Home Health Services	$0	$0	$0	$0	20%
Cardiac/Intensive Cardiac/ Pulmonary Rehab	$10 per day (72 day limit)	$10 per day (72 day limit)	$10 per day (72 day limit)	$10 per day (72 day limit)	20%
Emergency Care/Urgent Care	$65/$20 (Waived if admitted)	$65/$25 (Waived if admitted)	$65/$25 (Waived if admitted)	$65/$25 (Waived if admitted)	$65/$25 (Waived if admitted)
Outpatient Hospital/Ambulatory Surgery	$250	Deductible Applies	Deductible Applies	$275	20%
Outpatient MRI, CT, PET Scans	$100 per day	Deductible Applies	Deductible Applies	$100 per day	20%
Outpatient Chemotherapy, Radiation Therapy (standard), Nuclear Medicine/Outpatient Radiation Therapy (high-tech)	$25 per day/$60 per day	Deductible Applies	Deductible Applies	20%	No Coverage
Outpatient Lab	$5	Deductible Applies	Deductible Applies	$5	20%
Outpatient X-Rays	$25	Deductible Applies	Deductible Applies	$25	20%
Outpatient Mental Health	$10 Group/$25 Individual	$10 Group/$25 Individual	$10 Group/$25 Individual	$10 Group/$25 Individual	20%
Ambulance	$100 (Waived if admitted)	Deductible Applies	Deductible Applies	$100 (Waived if admitted)	20% (Waived if admitted)
Medicare Covered Preventive Services	$0	$0	$0	$0	$25
Part B Drugs	20%	20%	20%	20%	No Coverage

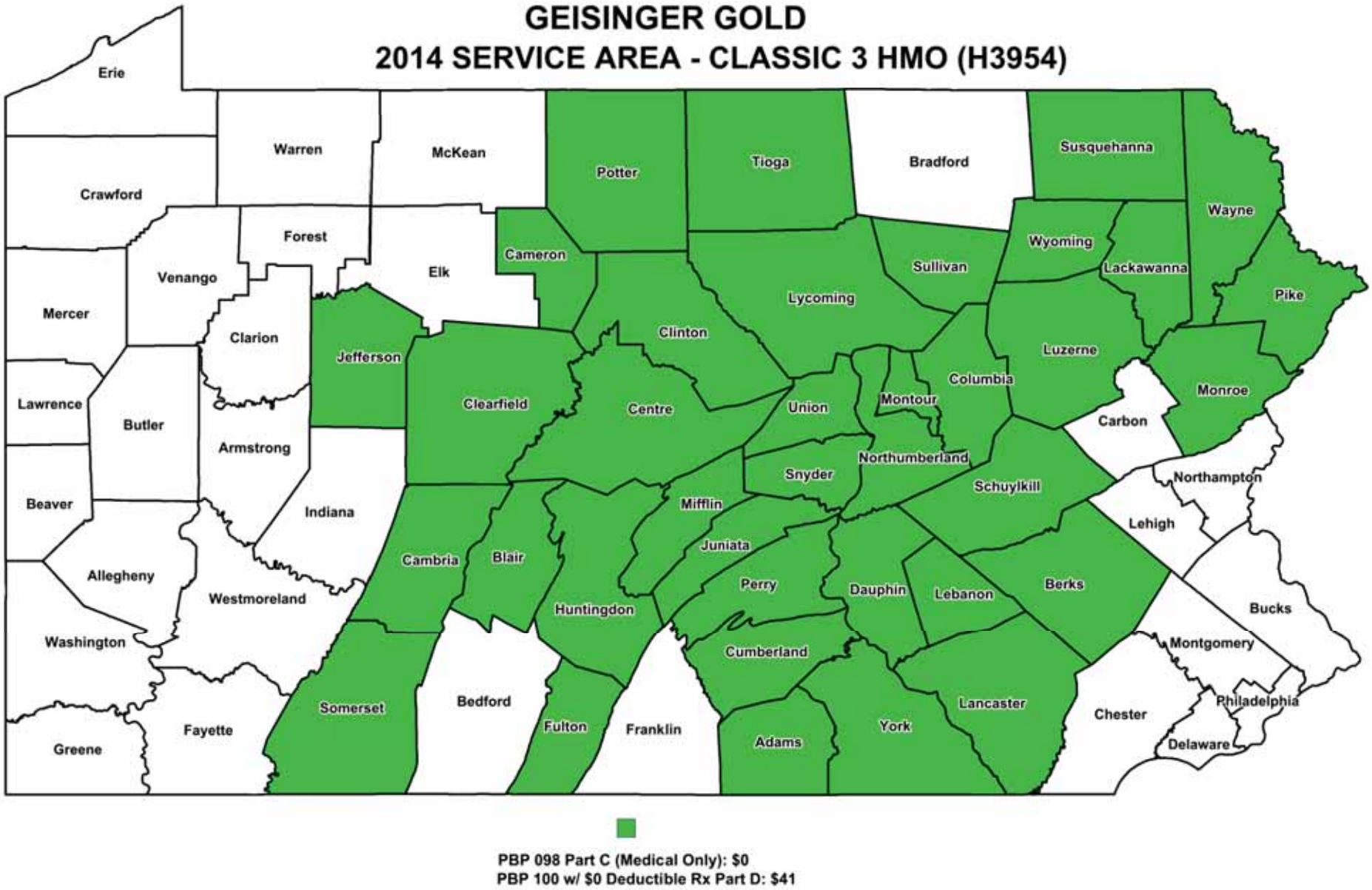
Note: 2014 benefits, premiums & cost-sharing are pending CMS approval as of 8/8/13.

BENEFIT DESCRIPTION	CLASSIC 1 (HMO)	CLASSIC 3 (HMO)	CLASSIC 4 (HMO)	CLASSIC PLUS (HMO-POS)	
	In-Network	In-Network	In-Network	In-Network	Out-of-Network
DME/DME-Related Supplies, Prosthetics & Medical Supplies	20%	After Deductible is met 20%	After Deductible is met 20%	20%	20%
Diabetes Monitoring, Training & Supplies	$0 Preferred Brand Glucometer every 2 years. 0% Preferred Brand Diabetic Test Strips. 0% lancets and lancet devices, any brand. 20% Non-Preferred Brand Diabetic Test Strips. 20% Non-Preferred Brand Glucometers. Prior Auth required to obtain non-preferred brand meters or strips. Prior Auth required to obtain more than 200 Strips per month. Prior Auth required to obtain glucometer more often than every 2 years.	$0 Preferred Brand Glucometer every 2 years. 20% all other Diabetic Testing Supplies (All Strips, all lancets, non-preferred meters, etc.) Strips must be preferred brand unless prior auth. 200 Test Strip limit unless auth for more	$0 Preferred Brand Glucometer every 2 years. 20% all other Diabetic Testing Supplies (All Strips, all lancets, non-preferred meters, etc.) Strips must be preferred brand unless prior auth. 200 Test Strip limit unless auth for more	$0 Preferred Brand Glucometer every 2 years. 20% all other Diabetic Testing Supplies (All Strips, all lancets, non-preferred meters, etc.) Strips must be preferred brand unless prior auth. 200 Test Strip limit unless auth for more	20%. Strips must be preferred brand unless prior auth. 200 test strip limit unless auth for more
Dental Services (Preventive): Oral Exam with or without Prophylaxis (cleaning)/X-rays	$20; every 6 months/ $20 bitewing only; $30 panoramic & all other types	$20; every 6 months/ $20 bitewing only; $30 panoramic & all other types	$20; every 6 months / $20 bitewing only; $30 panoramic & all other types	$20; every 6 months/ $20 bitewing only; $30 panoramic & all other types	20%
Vision Exam (Medical) ($0 for glaucoma screen - office visit copay may apply)/Routine Vision Exams	$20/$20; 1 per year	$25/$25; 1 per year	$25/$25; 1 per year	$20/$20; 1 per year	20%
Eyewear: Routine Eyewear, Non-Medicare Covered. Contact Lenses, Eyeglasses, Lenses and Frames	$0 $200 maximum benefit every 2 years	$0 $200 maximum benefit every 2 years	$0 $200 maximum benefit every 2 years	$0 $200 maximum benefit every 2 years	$0 $200 maximum benefit every 2 years
Hearing Exams - Diagnostic Only/ Routine Hearing Exams	$20/$20; 1 per year	$25/$25	$25/$25	$20/$20; 1 per year	20%/20%; 1 per year
Hearing Aids/Fitting for Hearing Aids	$0 $800 maximum benefit; every 3 years (fitting/eval. falls under this limit)	$0 $800 maximum benefit; every 3 years (fitting/eval. falls under this limit)	$0 $800 maximum benefit; every 3 years (fitting and eval. Included in this max.)	$0 $800 maximum benefit; every 3 years (fitting/eval. falls under this limit)	$0 $1000 maximum benefit; every 3 years
Part D Prescription Drugs	$0 deductible Rx included	$0 deductible Rx included	$0 deductible Rx included	$0 deductible Rx included	$0 deductible Rx included
Preferred Generic	$3	$3	$3	$3	$3
Non-Preferred Generic	$7	$10	$10	$7	$7
Preferred Brand	$39	$39	$39	$39	$39
Non-Preferred Brand	$69	$80	$80	$69	$69
Specialty Drugs	33%	33%	33%	33%	33%

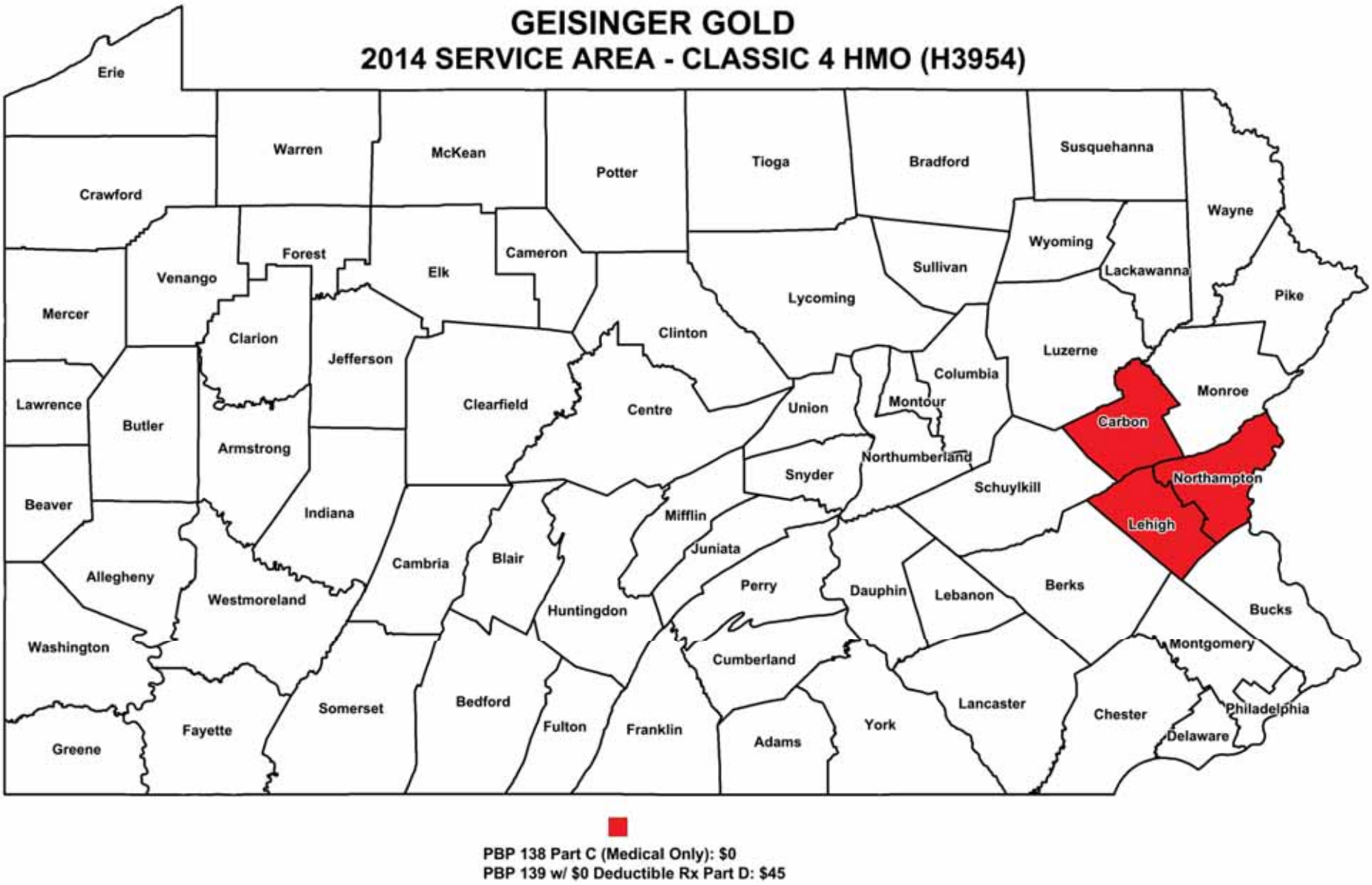
Note: 2014 benefits, premiums & cost-sharing are pending CMS approval as of 8/8/13.



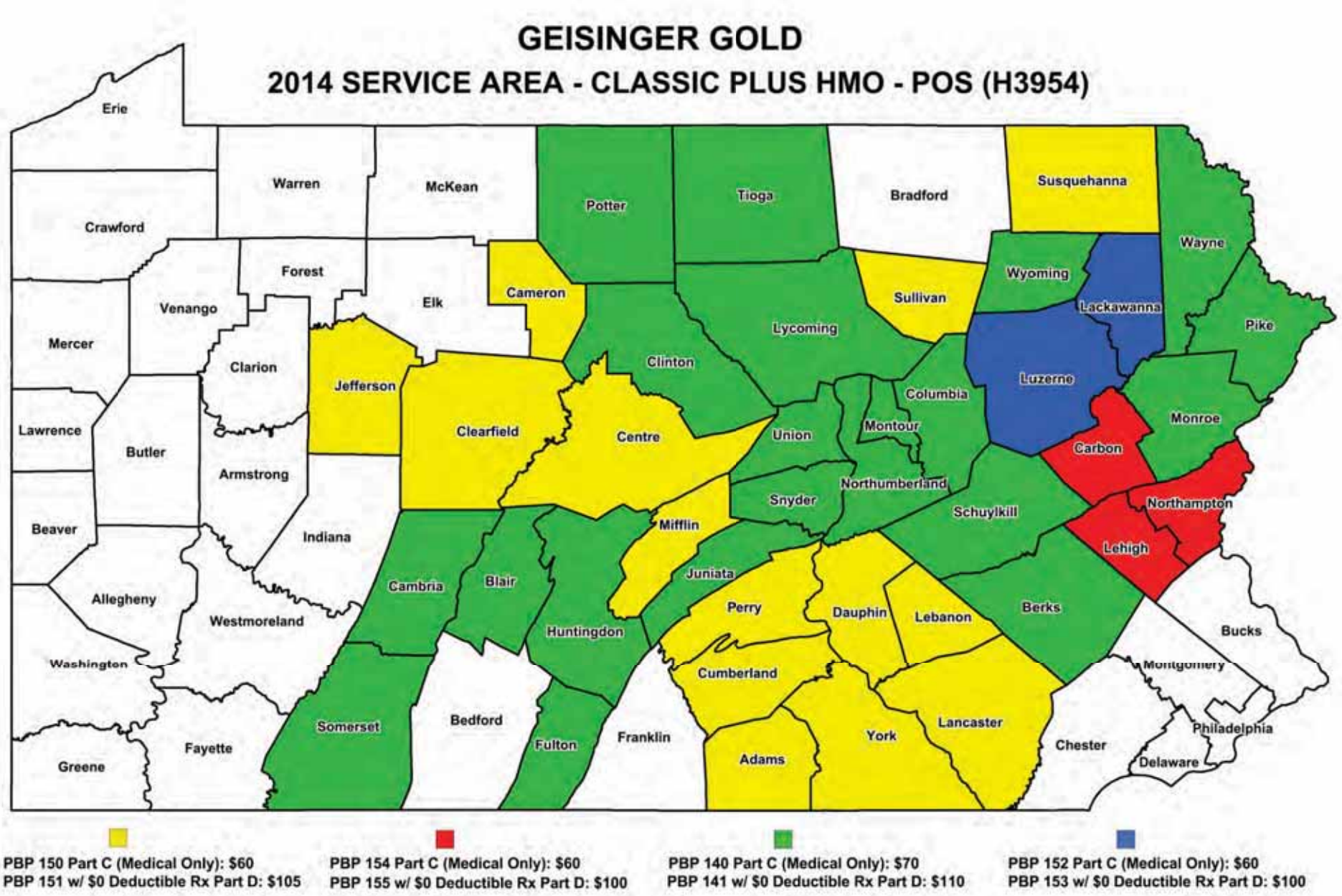
Note: 2014 benefits, premiums & cost-sharing are pending CMS approval as of 8/8/13.



Note: 2014 benefits, premiums & cost-sharing are pending CMS approval as of 8/8/13.



Note: 2014 benefits, premiums & cost-sharing are pending CMS approval as of 8/8/13.



Note: 2014 benefits, premiums & cost-sharing are pending CMS approval as of 8/8/13.

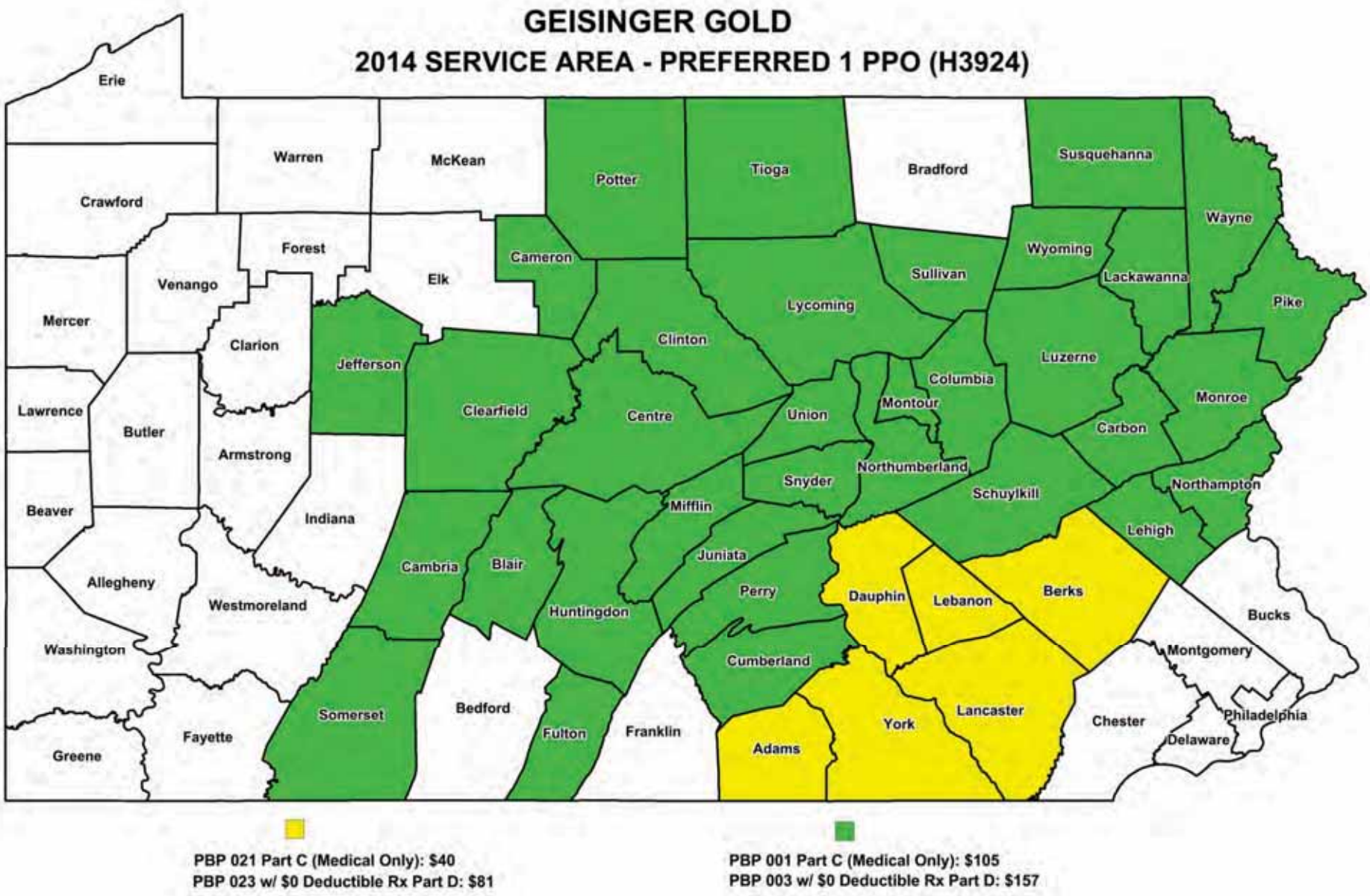
Preferred PPO

BENEFIT DESCRIPTION	PREFERRED 1 (PPO)		PREFERRED 2 (PPO)		PREFERRED 3 (PPO)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Premium	see map		see map		see map	
Plan Deductible	$195 in & out-of-network combined		$100 in & out-of-network combined		$120 in & out-of-network combined	
Plan Out-of-Pocket Maximum	$3,400 In-Network only	$5,100 In & Out combined	$3,900 In-Network only	$5,600 In & Out combined	$3,400 In-Network only	$5,100 In & Out combined
PCP/SCP (includes annual routine physical)	$7/$25	After Deductible is met $20/ After Deductible is met $35	After Deductible is met $20/ After Deductible is met $35	After Deductible is met $30/ After Deductible is met $45	$10/$25	After Deductible is met $20/ After Deductible is met $35
Physical, Speech & Occupational Therapy Services	$25 per day	After Deductible is met 20%	After Deductible is met $35	After Deductible is met 25%	$25 per day	After Deductible is met 20%
Chiropractic Services (Original Medicare Benefit)	After Deductible is met $20	After Deductible is met $35	After Deductible is met $20	After Deductible is met $45	After Deductible is met $20	After Deductible is met $35
Podiatry (Original Medicare Benefit)/Routine Nail Trimming	$25/$0 - 4 per year	After Deductible is met $35/ $35 - 4 per year	After Deductible is met $35/ After Deductible is met $0 - 4 per year	After Deductible is met $45/ After Deductible is met $45 - 4 per year	$25/$0 - 4 per year	After Deductible is met $35/ After Deductible is met $35 - 4 per year
Inpatient Hospital - Acute/Rehab	After Deductible is met $440 per stay	After Deductible is met 20%	After Deductible is met $225 per day (days 1-5)	After Deductible is met 25%	After Deductible is met $275 per stay	After Deductible is met 20%
Inpatient Psychiatric Hospital	After Deductible is met $440 per stay	After Deductible is met 20%	After Deductible is met $225 per day (days 1-5)	After Deductible is met 25%	After Deductible is met $275 per stay	After Deductible is met 20%
Skilled Nursing Facility	After Deductible is met $50 per day (days 1-20) $152 per day (days 21-35) $0 per day (days 36-100)	After Deductible is met 20%	After Deductible is met $25 per day (days 1-20) $152 per day (days 21-43) $0 per day (days 44-100)	After Deductible is met 25%	After Deductible is met $50 per day (days 1-20) $152 per day (days 21-35) $0 per day (days 36-100)	After Deductible is met 20%
Home Health Services	$0	After Deductible is met 20%	$0	After Deductible is met 25%	$0	After Deductible is met 20%
Cardiac/Intensive Cardiac/ Pulmonary Rehab	$10 per day (72 day limit)	After Deductible is met 20%	After Deductible is met $10 per day (72 day limit)	After Deductible is met 25%	$10 per day (72 day limit)	After Deductible is met 25%
Emergency Care/Urgent Care	$65/$25 (Waived if admitted)	$65/$25 (Waived if admitted)	$65/$35 (Waived if admitted)	$65/$35 (Waived if admitted)	$65/$25 (Waived if admitted)	$65/$25 (Waived if admitted)
Outpatient Hospital/Ambulatory Surgery	After Deductible is met $250	After Deductible is met 20%	After Deductible is met $375	After Deductible is met 25%	After Deductible is met $125	After Deductible is met 20%
Outpatient MRI, CT, PET Scans	After Deductible is met $125 per day	After Deductible is met 20%	After Deductible is met 20%	After Deductible is met 25%	After Deductible is met $125 per day	After Deductible is met 20%
Outpatient Chemotherapy, Radiation Therapy (standard), Nuclear Medicine/Outpatient Radiation Therapy (high-tech)	After Deductible is met $45 per day	After Deductible is met 20%	After Deductible is met 20%	After Deductible is met 25%	After Deductible is met $45 per day	After Deductible is met 20%
Outpatient Lab	After Deductible is met $10	After Deductible is met 20%	After Deductible is met $15	After Deductible is met 25%	After Deductible is met $10	After Deductible is met 20%
Outpatient X-Rays	After Deductible is met $45	After Deductible is met 20%	After Deductible is met $45 per day	After Deductible is met 25%	$45 per day	After Deductible is met 20%
Outpatient Mental Health	$10 Group/$25 Individual	After Deductible is met 20%	After Deductible is met $10 Group/$25 Individual	After Deductible is met 25%	$10 Group/$25 Individual	After Deductible is met 20%
Ambulance	After Deductible is met $150 (Waived if admitted)	After Deductible is met 20% (Waived if admitted)	After Deductible is met $150 (Waived if admitted)	After Deductible is met 25% (Waived if admitted)	After Deductible is met $150 (Waived if admitted)	After Deductible is met 20% (Waived if admitted)
Medicare Covered Preventive Services	$0	$35	$0	$45	$0	$35
Part B Drugs	After Deductible is met 20%	After Deductible is met 20%	20%	After Deductible is met 25%	After Deductible is met 20%	After Deductible is met 20%

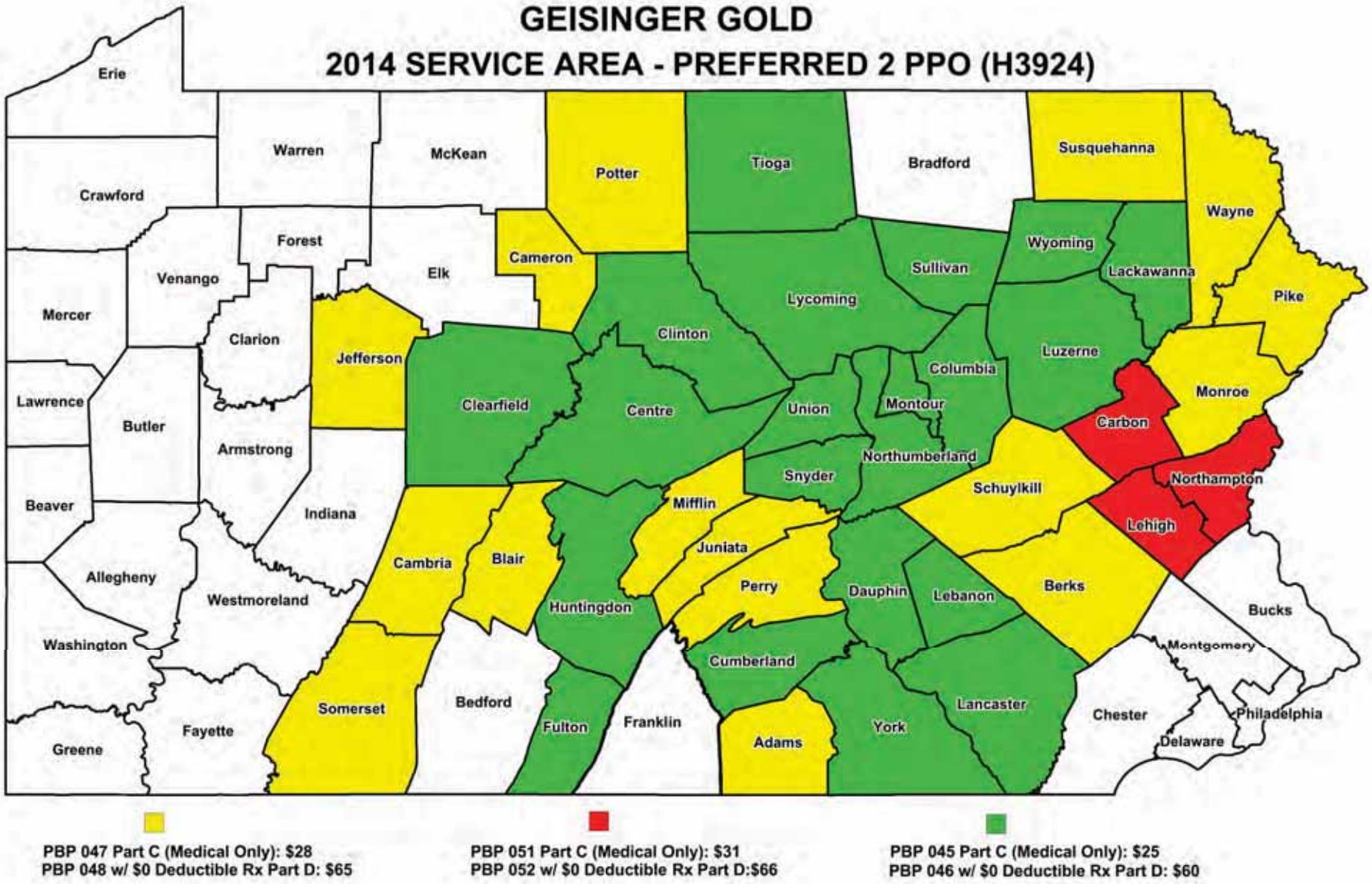
Note: 2014 benefits, premiums & cost-sharing are pending CMS approval as of 8/8/13.

BENEFIT DESCRIPTION	PREFERRED 1 (PPO)		PREFERRED 2 (PPO)		PREFERRED 3 (PPO)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
DME/DME-Related Supplies, Prosthetics & Medical Supplies	After Deductible is met 20%	After Deductible is met 20%	After Deductible is met 20%	After Deductible is met 25%	After Deductible is met 20%	After Deductible is met 20%
Diabetes Monitoring, Training & Supplies	$0 Preferred Brand Glucometer every 2 years. 20% all other Diabetic Testing Supplies (All Strips, all lancets, non-preferred meters, etc.) Strips must be preferred brand unless prior auth. 200 Test Strip limit unless auth for more	After Deductible is met 20% Strips must be preferred brand unless prior auth. 200 Test Strip limit unless auth for more.	$0 Preferred Brand Glucometer every 2 years. 20% all other Diabetic Testing Supplies (All Strips, all lancets, non-preferred meters, etc.) Strips must be preferred brand unless prior auth. 200 Test Strip limit unless auth for more	After Deductible is met 25%. Strips must be preferred brand unless prior auth. 200 Test Strip limit unless auth for more.	$0 Preferred Brand Glucometer every 2 years. 20% all other Diabetic Testing Supplies (All Strips, all lancets, non-preferred meters, etc.) Strips must be preferred brand unless prior auth. 200 Test Strip limit unless auth for more	After Deductible is met 20%. Strips must be preferred brand unless prior auth. 200 Test Strip limit unless auth for more.
Dental Services (Preventive): Oral Exam with or without Prophylaxis (cleaning)/X-rays	$20 every 6 months/ $20 bitewing only $30 panoramic & all other types	20%	$20 every 6 months/ $20 bitewing only $30 panoramic & all other types	25%	$20 every 6 months/ $20 bitewing only $30 panoramic & all other types	20%
Vision Exam (Medical) ($0 for glaucoma screen - office visit copay may apply)/Routine Vision Exams	$25/$25; 1 per year	After Deductible is met $35/ After Deductible is met $35; 1 per year	After Deductible is met $35/ After Deductible is met $35; 1 per year	After Deductible is met $45/ After Deductible is met $45; 1 per year	$25/$25; 1 per year	After Deductible is met $35/ After Deductible is met $35; 1 per year
Eyewear: Routine Eyewear, Non-Medicare Covered. Contact Lenses, Eyeglasses, Lenses and Frames	$0 $200 maximum benefit every 2 years	$0 $200 maximum benefit every 2 years	$0 $200 maximum benefit every 2 years	$0 $200 maximum benefit every 2 years	$0 $200 maximum benefit every 2 years	$0 $200 maximum benefit every 2 years
Hearing Exams - Diagnostic Only/ Routine Hearing Exams	$25/$25; 1 per year	After Deductible is met $35/ After Deductible is met $35; 1 per year	After Deductible is met $35/ After Deductible is met $35; 1 per year	After Deductible is met $45/ After Deductible is met $45; 1 per year	$25/$25; 1 per year	After Deductible is met $35/ After Deductible is met $35; 1 per year
Hearing Aids/Fitting for Hearing Aids	$0 $800 maximum benefit every 3 years	$0 $800 maximum benefit every 3 years	$0 $800 maximum benefit every 3 years (fitting/eval. falls under this limit)	$0 $800 maximum benefit every 3 years	$0 $800 maximum benefit every 3 years	$0 $800 maximum benefit every 3 years
Part D Prescription Drugs	$0 deductible Rx included	$0 deductible Rx included	$0 deductible Rx included	$0 deductible Rx included	$0 deductible Rx included	$0 deductible Rx included
Preferred Generic	$3	$3	$3	$3	$3	$3
Non-Preferred Generic	$10	$10	$10	$10	$10	$10
Preferred Brand	$39	$39	$39	$39	$39	$39
Non-Preferred Brand	$80	$80	$80	$80	$80	$80
Specialty Drugs	33%	33%	33%	33%	33%	33%

Note: 2014 benefits, premiums & cost-sharing are pending CMS approval as of 8/8/13.

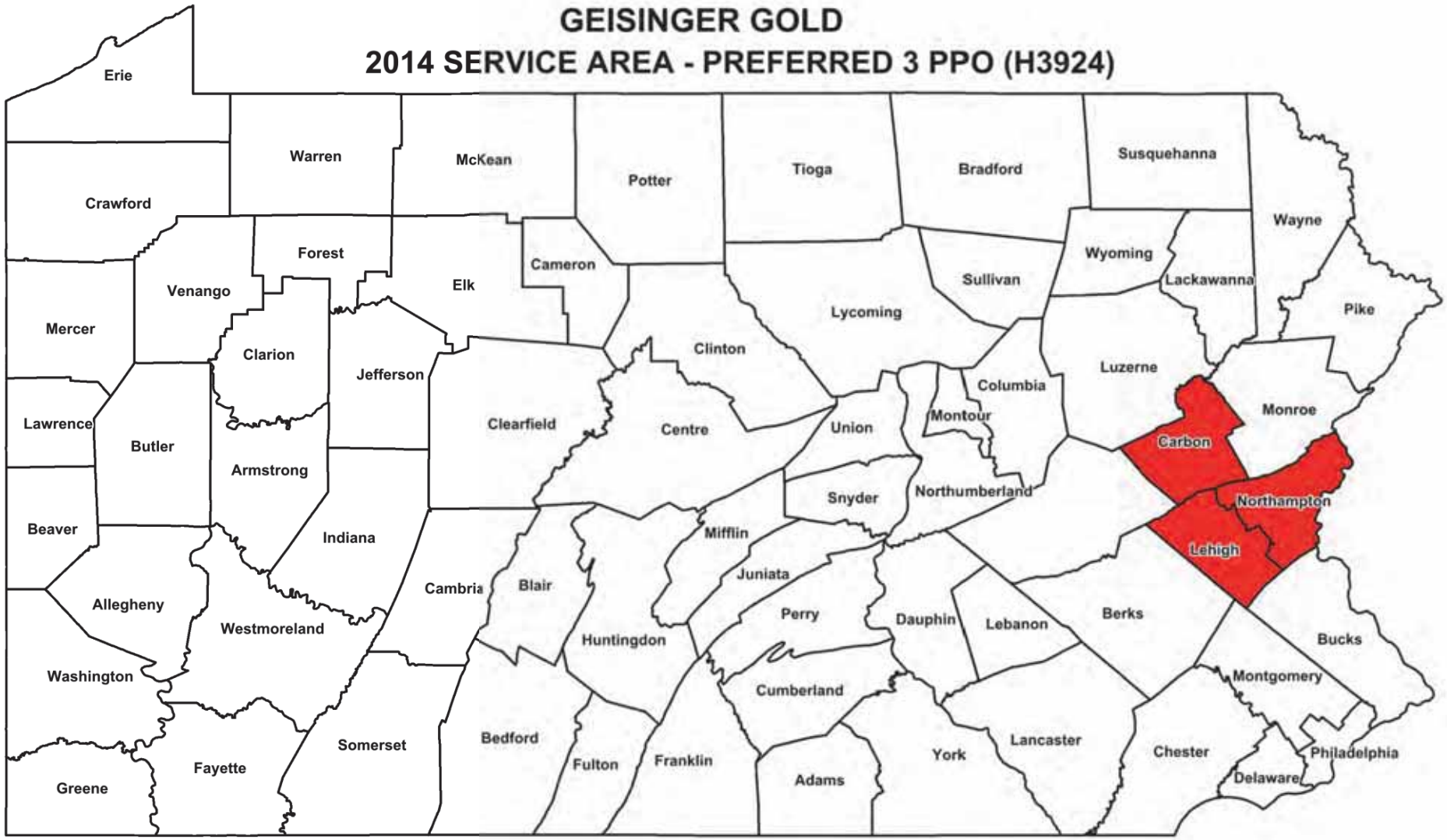


Note: 2014 benefits, premiums & cost-sharing are pending CMS approval as of 8/8/13.



Note: 2014 benefits, premiums & cost-sharing are pending CMS approval as of 8/8/13.

GEISINGER GOLD
2014 SERVICE AREA - PREFERRED 3 PPO (H3924)



PBP 053 Part C (Medical Only): $96
PBP 054 w/ $0 Deductible Rx Part D: $148

Note: 2014 benefits, premiums & cost-sharing are pending CMS approval as of 8/8/13.

Secure HMO SNP

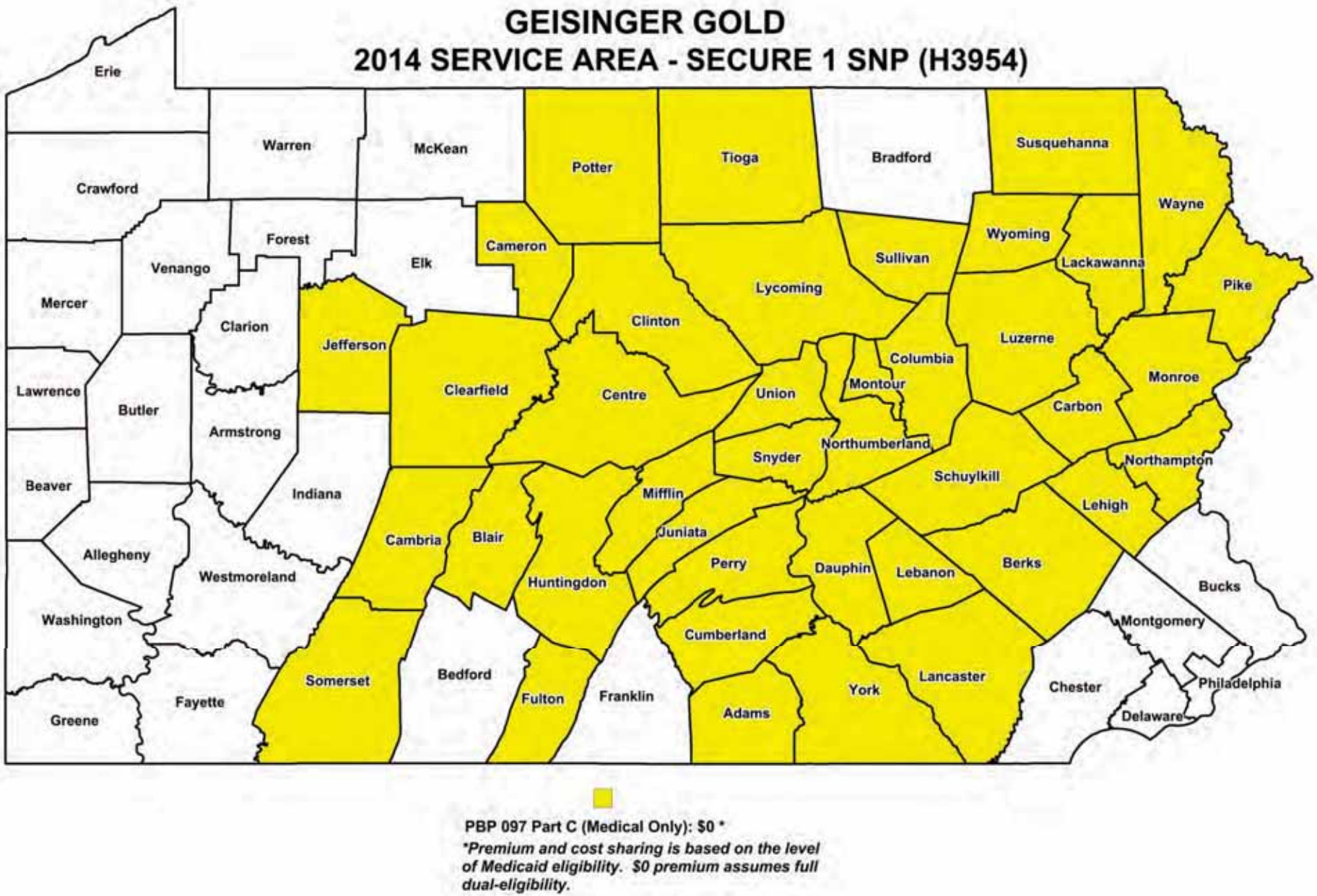
BENEFIT DESCRIPTION	SECURE 1 (HMO SNP)
	In-Network
Plan Premium	see map
Plan Deductible	None to Member Medicare FFS Part A (Inpatient) Deductible billed to Medicaid No Deductible on Part B
Plan Out-of-Pocket Maximum	$6,700
PCP/SCP (includes annual routine physical)	$0 to member $0 copay for PCP not billed to Medicaid 20% Medicare FFS billed to Medicaid for SCP
Physical, Speech & Occupational Therapy Services	$0 to member 20% Medicare FFS Cost Sharing billed to Medicaid
Chiropractic Services (Original Medicare Benefit)	$0 to member 20% Medicare FFS Cost Sharing billed to Medicaid
Podiatry (Original Medicare Benefit)/ Routine Nail Trimming	$0 to member 20% Medicare FFS Cost Sharing billed to Medicaid
Inpatient Hospital - Acute/Rehab	$0 to member Medicare FFS Part A Deductible and Part A Cost Sharing billed to Medicaid
Inpatient Psychiatric Hospital	$0 to member Medicare FFS Part A Deductible and Part A Cost Sharing billed to Medicaid
Skilled Nursing Facility	$0 to member Medicare FFS Part A Deductible and Part A Cost Sharing billed to Medicaid
Home Health Services	$0
Cardiac/Intensive Cardiac/Pulmonary Rehab	$0 to member 20% Medicare FFS Cost Sharing billed to Medicaid
Emergency Care/Urgent Care	$0 to member $65 copay billed to Medicaid for ER. 20% Medicare FFS Cost Sharing Billed to Medicaid for Urgent Care
Outpatient Hospital/Ambulatory Surgery	$0 to member 20% Medicare FFS Cost Sharing billed to Medicaid
Outpatient MRI, CT, PET Scans	$0 to member 20% Medicare FFS Cost Sharing billed to Medicaid
Outpatient Chemotherapy, Radiation Therapy (standard), Nuclear Medicine/ Outpatient Radiation Therapy (high-tech)	$0 to member 20% Medicare FFS Cost Sharing billed to Medicaid
Outpatient Lab	$0 to member 20% Medicare FFS Cost Sharing billed to Medicaid

Note: 2014 benefits, premiums & cost-sharing are pending CMS approval as of 8/8/13.

BENEFIT DESCRIPTION	SECURE 1 (HMO SNP)
	In-Network
Outpatient X-Rays	$0 to member 20% Medicare FFS Cost Sharing billed to Medicaid
Outpatient Mental Health	$0 to member 20% Medicare FFS Cost Sharing billed to Medicaid
Ambulance	$0 to member 20% Medicare FFS Cost Sharing billed to Medicaid
Medicare Covered Preventive Services	$0
Part B Drugs	$0 to member 20% Medicare FFS Cost Sharing billed to Medicaid
DME/DME-Related Supplies, Prosthetics & Medical Supplies	$0 to member 20% Medicare FFS Cost Sharing billed to Medicaid
Diabetes Monitoring, Training & Supplies	20% all other Diabetic Testing Supplies (All Strips, all lancets, non-preferred meters, etc.) Strips must be preferred brand unless prior auth. 200 Test Strip limit unless auth for more.
Dental Services (Preventive): Oral Exam with or without Prophylaxis (cleaning)/ Dental X-rays/Dentures	Max. $2,000 per year combined for all non-Medicare dental; Incl. simple fillings and extractions/$400 denture allowance incl. in $2,000 max
Vision Exam (Medical) ($0 for glaucoma screen - office visit copay may apply)/ Routine Vision Exams	$0/$0; 1 per year
Eyewear: Routine Eyewear, Non-Medicare Covered. **Contact Lenses, Eyeglasses, Lenses and Frames**	$0 $275 maximum benefit per year
Hearing Exams - Diagnostic Only/ Routine Hearing Exams	$0/$0; 1 per year
Hearing Aids/Fitting for Hearing Aids	$0 $1,300 maximum benefit; every 3 years (fitting/eval. falls under this limit)
Part D Prescription Drugs	Part D drugs covered with appropriate LIS cost-sharing & premium subsidies
Over-the-Counter Drugs	$65 allowance every 3 months

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

Note: 2014 benefits, premiums & cost-sharing are pending CMS approval as of 8/8/13.



Note: 2014 benefits, premiums & cost-sharing are pending CMS approval as of 8/8/13.

Reserve MSA

Geisinger Gold Reserve MSA

- **What is a Medical Savings Account Plan?**
  - A high deductible Medicare Advantage plan that combined with a bank account
  - The plan deposits money from Medicare into the bank account
  - The deposit can be used to pay for Qualified Medical Expenses and is tax-free, including non-Medicare covered expenses (vision, dental, etc.)
    - Only Medicare-covered expenses count towards the deductible (doctor visits, inpatient hospital stays, lab tests, etc.)

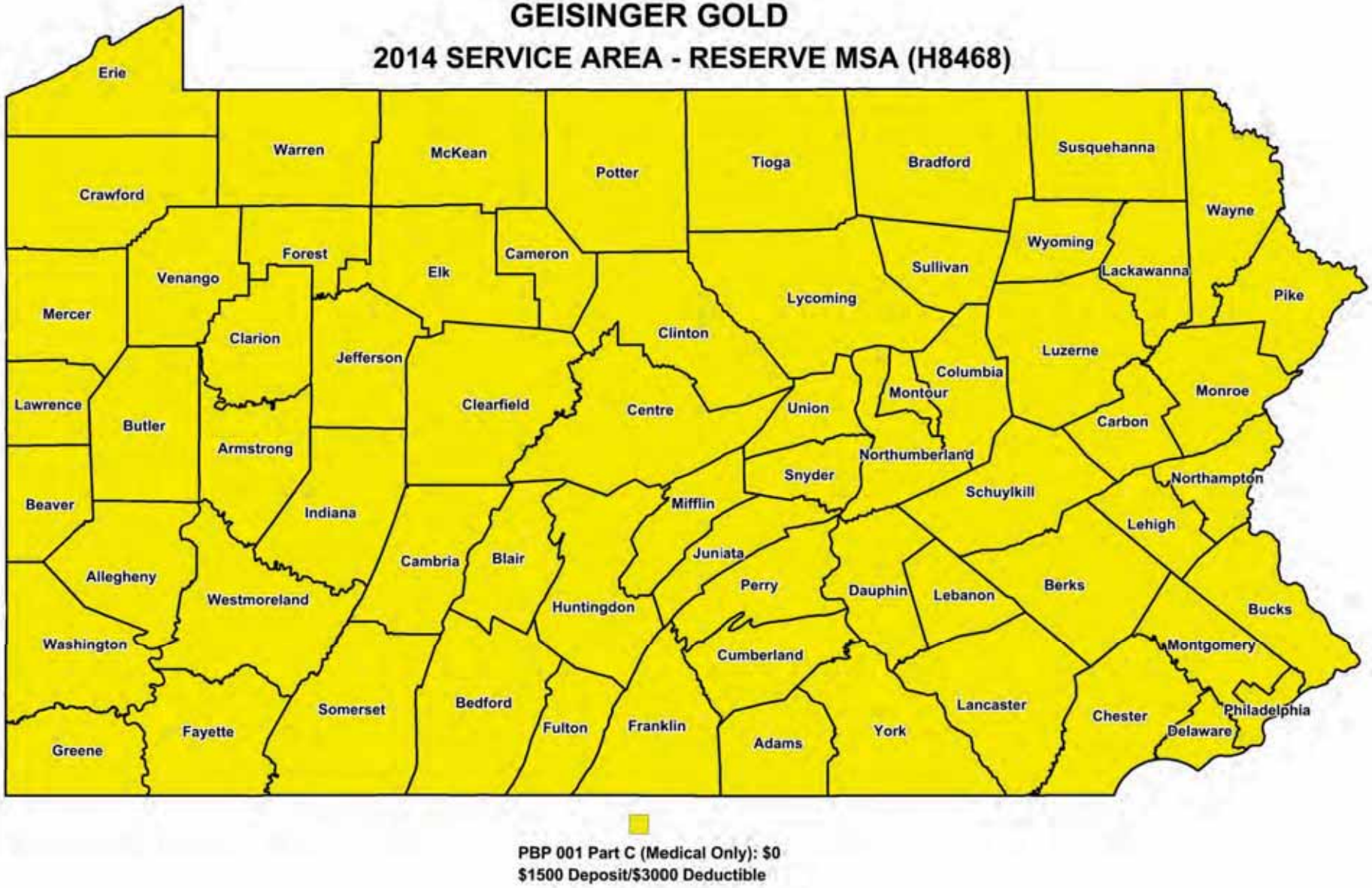
- **Geisinger Gold Reserve MSA Plan Design**
  - $0 monthly premium
  - Members continue to pay monthly Medicare Part B premium
  - $1,500 annual account deposit
  - $3,000 annual deductible (deposit can be used to offset annual deductible)
  - Once the yearly $3,000 deductible is met, Geisinger Gold pays all Medicare-covered expenses
  - Prescription drug coverage is not included (members may purchase a stand-alone PDP)
    - Deposit money used to pay for drug plan copays and deductibles do **not** count towards the MSA plan deductible
  - Any money remaining in the account at the end of the calendar year rolls over to the next year

- **MSA Plan Provider Network**
  - MSA members can receive care from any provider who accepts Medicare assignment
  - No PCP required
  - No referrals required
  - Non-contracted providers must accept Medicare-allowed reimbursement rates

- **Claims**
  - Member presents their Geisinger Gold Reserve MSA ID card to provider
  - Provider does **not** bill member at site of service, but sends bill to the health plan
  - Health Plan adjudicates bill charges against the Medicare fee schedule
  - Provider then bills the member

  NOTE: if provider refuses to bill Geisinger Gold, the member may submit their bill to Geisinger Gold for adjudication and payment of Medicare allowed charges. This is **not** the preferred method.

- **When to Enroll**
  - AEP (October 15th – December 7th)
  - ICEP (age-in)
    - If the member elects the MSA as an age-in, the deposit and deductible will be pro-rated 1/12th for each month of the year the member was not enrolled after January 1st



Note: 2014 benefits, premiums & cost-sharing are pending CMS approval as of 8/8/13.

Medicare Part D Prescription Drug Coverage

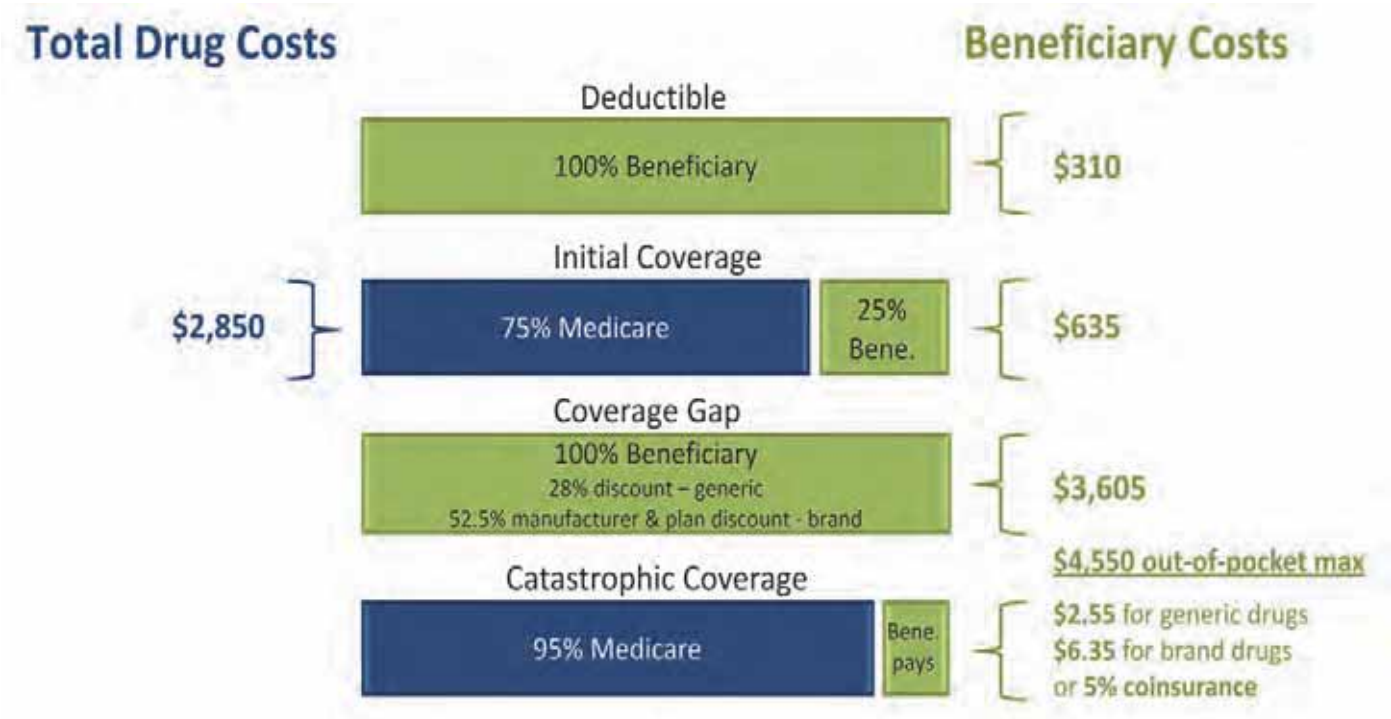
Medicare Part D Prescription Drug Coverage

(Beneficiary must enroll in a Geisinger Gold Medicare Advantage plan to elect Part D coverage)

Part D Standard Benefit Design (Secure 1 only)

- Dual-Eligibles
  - Member pays $310 annual deductible
  - Member pays 25% of allowable costs up to $2,850 (25% of [$2,850 - $310]) = $635
  - Coverage gap: member pays the next $3,605 (actual amount member pays depends on the level of extra help they receive)
  - After $4,550 paid out-of-pocket ($310 + $635 + $3,605 = $4,550) catastrophic coverage begins
  - Member pays nominal amount ($2.55/$6.35 copay or either 5% coinsurance, whichever is greater)

  Note: actual cost-sharing depends on additional coverage



Geisinger Gold Part D Enhanced Benefit Design

Deductible

$0 Deductible Rx

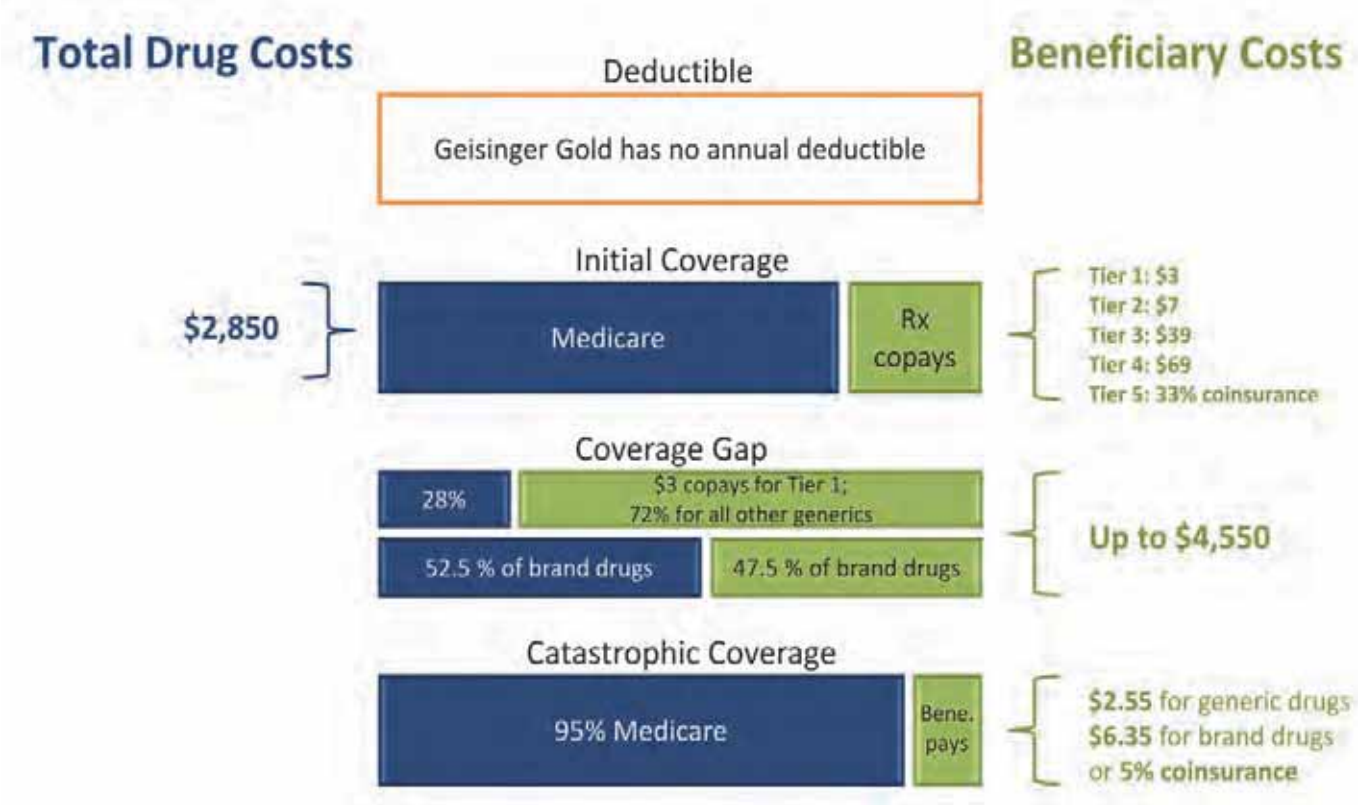
Initial Coverage: Until total yearly drug costs reach $2,850, member pays:

Retail Tier 1 *(Preferred Generic)*	**$3** copay for 1 month (31 day) supply
Mail Order Tier 1 *(Preferred Generic)*	**$9** copay for 3 month (90 day) supply
Retail Tier 2 *(Non-Preferred Generic)*	**$7** (Classic 1 & Classic Plus) or **$10** (all other plans) copay for 1 month (31 day) supply
Mail Order Tier 2 *(Non-Preferred Generic)*	**$21** (Classic 1 & Classic Plus) or **$30** copay for 3 month (90 day) supply
Retail Tier 3 *(Preferred Brand)*	**$39** copay for 1 month (31 day) supply
Mail Order Tier 3 *(Preferred Brand)*	**$117** copay for 3 month (90 day) supply
Retail Tier 4 *(Non-Preferred Brand)*	**$69** (Classic 1 & Classic Plus) or **$80** copay for 1 month (31 day) supply
Mail Order Tier 4 *(Non-Preferred Brand)*	**$207** (Classic 1 & Classic Plus) or **$240** copay for 3 month (90 day) supply
Retail Tier 5 *(Specialty Drugs)*	**33% co-insurance** for 1 month (31 day) supply

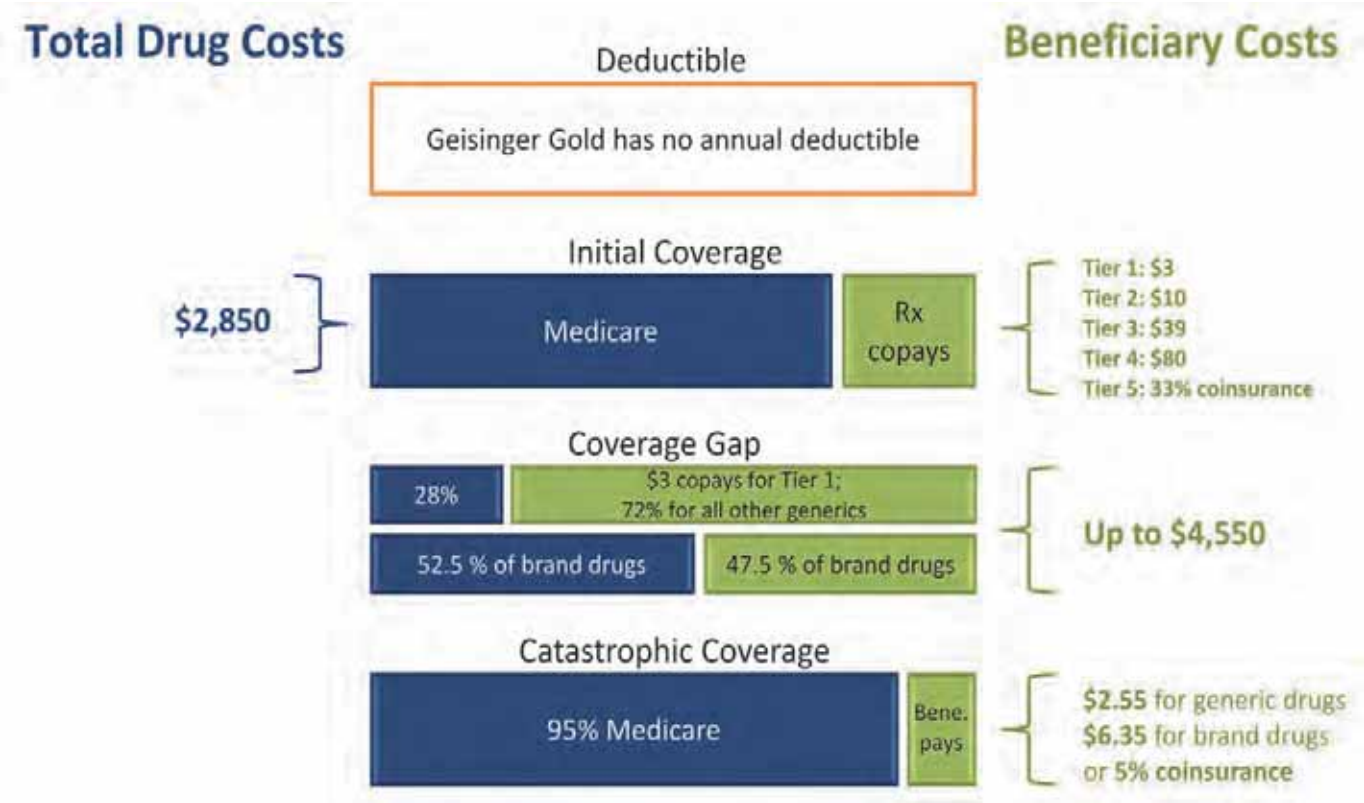
Coverage Gap: After total yearly costs reach $2,850, but before members yearly out of pocket reaches $4,550, members enter the coverage gap. While in the gap, Geisinger Gold members still have access to Tier 1 generic medications at $3 copays. For other generic medications, member pays 72% of the cost for the generic medications and 47.5% of the cost for brand medications.

Catastrophic Coverage: After yearly out of pocket reaches $4,550, member pays $2.55 copay for generic (including brand drugs treated as generic) and $6.35 copay for all other drugs or 5% coinsurance, whichever amount is greater.

Geisinger Gold Part D Enhanced Benefit Design – Classic 1 & Classic Plus



Geisinger Gold Part D Enhanced Benefit Design – All Other Plans



TrOOP (True-Out-Of-Pocket) Costs

- **What Counts Towards 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.

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	2014 Rx Deductible	2014 Rx Copayment	2014 Rx Catastrophic
No Drug	n/a	n/a	n/a
Premium Subsidy 0%	$310	Varies based on plan options	$2.55 / $6.35*
Premium Subsidy 25% (income > 145% & < 150% FPL)	$63	15% coinsurance	$2.55 / $6.35
Premium Subsidy 50% (income >140% & < 145% FPL)	$63	15% coinsurance	$2.55 / $6.35
Premium Subsidy 75% (income > 135% & < 140% FPL)	$63	15% coinsurance	$2.55 / $6.35
Premium Subsidy 100% (income < 135% FPL)	$63	15% coinsurance	$2.55 / $6.35
Premium Subsidy 100% (income < 135% FPL)	$0	$2.55 / $6.35	$0
Premium Subsidy 100% (income <100% FPL)	$0	$1.20 / $3.60	$0
Full Dual Institutionalized 100%	$0	$0	$0

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

- **2013 Federal Poverty Level Guidelines** *(2014 FPL Guidelines to be released January 2014)*

# of people in family/household	Poverty Guideline (100% of the FPL)
1	$11,490
2	$15,510
3	$19,530
4	$23,550
5	$27,570
6	$31,590
7	$35,610
8	$39,630

Note: families/households with more than 8 persons, add $4,020 for each additional person

Part B & Part D Income Related Monthly Adjustment Amount

Part B & Part D Income Related Monthly Adjustment Amount

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

- Higher income individuals will pay higher Part B *($104.90 in 2013*) & 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 premium.
- Part B & Part D IRMAA is reviewed annually by the Social Security Administration

** Income levels & premiums may change for 2014*

Income Level (individual tax returns)	Income Level (joint tax returns)	*2013 Part B Monthly Premium Increase	2014 Part D Monthly Premium Increase
Less than or equal to $85,000	Less than or equal to $170,000	$0	$0
Greater than $85,000 and less than or equal to $107,000	Greater than $170,000 and less than or equal to $214,000	$42.00	$12.10
Greater than $107,000 and less than or equal to $160,000	Greater than $214,000 and less than or equal to $320,000	$104.90	$31.10
Greater than $160,000 and less than or equal to $214,000	Greater than $320,000 and less than or equal to $428,000	$167.80	$50.20
Greater than $214,000	Greater than $428,000	$230.80	$69.30

Income Level (individuals who are married but file separate tax returns)	*2013 Part B Monthly Premium Increase	2014 Part D Monthly Premium Increase
Less than or equal to $85,000	$0	$0
Greater than $85,000 and less than or equal to $129,000	$167.80	$50.20
Greater than $129,000	$230.80	$69.30

2014 Part D IRMAA formula calculation

$$\text{IRMAA } 35\% = \$32.42 \times \frac{35\% - 25.5\%}{25.5\%} = \$12.08 \text{ (rounded to } \$12.10)$$

PPACA Prescription Drug Discount Program

PPACA Prescription Drug Discount Program Information

- **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 2014 will receive a discount at the pharmacy:
    - Brand Name Drugs – 52.5% discount (50% manufacturer paid & 2.5% Medicare Part D plan paid)
    - Generic Drugs – 28% discount

- **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 wholly in the coverage gap

- **How is the Manufacturer's Coverage Gap Discount Calculated?**
  - The claim discount is based on the negotiated price:
    - Ingredient cost + Vaccine Administration Fee
    - The usual dispensing fee is excluded
    - Discount is applied to member TrOOP.
    - Example: Brand drug XYZ has an AWP (average wholesale price) of $50.00
      - Pharmacy's negotiated price is AWP-15% plus $1.25 dispensing fee = $43.75
      - The negotiated price for the AWP is $42.50.
      - The Member Discount is $22.31 (52.5%).
      - The Member Pays $20.19 (=47.5%) + $0.59 (=47.5%) = $20.78

- **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: Retire 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 52.5%, a discount of 28% is applied
  - MAC (maximum allowable cost) Drugs – priced below AWP negotiated rates - the entire cost is eligible for discount

PACE and PACENET

PACE and PACENET Information

- **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)
  - 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.

- **What are the coverage levels by income limits associated with the program?**

	2013 Income Limits*	2013 Cost Sharing*
PACE	Individuals: $14.5k or less	Generic Drugs: $6.00
	Married: $17.7k or less	Brand Drugs: $9.00

	2013 Income Limits*	2013 Cost Sharing*
PACENET	Individuals: $14.5k - $23.5k	Generic Drugs: $8.00
	Married: $17.7k - $31.5k	Brand Drugs: $15.00

** Income limits and cost sharing may change for 2014*

- **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 CMS benchmark ($35.50 for 2014)
  - PACE Members will be billed for any premium over benchmark

- **PACENET and Medicare Part D**
  - PACENET does not automatically pay Member Premium
  - PACENET has a monthly deductible equivalent to the CMS Benchmark ($35.50 for 2014)
  - PACE/MA-PD Member will receive a monthly premium notice from MA-PD
  - Monthly Part D plan premium for PACE partner plans is paid at the pharmacy and the member is no longer required to pay the PACENET deductible.
  - Premiums for PACE non-partner plans will be paid directly to the plan
    - If no prescriptions are billed in a month, the deductible is rolled into the next month.

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 1-800-498-9731.

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 1-800-498-9731 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 $35.50 (2014 Benchmark) . You would receive a bill for any monthly premium in excess of $35.50 (2014 Benchmark).

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.

Election and Enrollment Period Guidance

Election and Enrollment Period Guidance

Election Periods

- **Initial Coverage (ICEP)/Initial Enrollment Period (IEP):** Is the beneficiary new to Medicare? They can enroll 3 months before, the month of and up to 3 months after their 65th birthday. Their effective date would be the first day of the month of entitlement to Medicare Part A/B, or the first of the month following the month the election request is made if after entitlement has occurred.

- **Annual Election Period (AEP):** The Annual Election Period (AEP) will occur between October 15 and December 7, 2013. The AEP is also referred to as the "Fall Open Enrollment" season and the "Open Enrollment Period for Medicare Advantage and Medicare prescription drug coverage." The coverage effective date is January 1 of the following year. Elections must be received by Geisinger Health Plan prior to their effective date.

- **Medicare Advantage Disenrollment Period (MADP):** Medicare Advantage plan members have an opportunity each year to prospectively disenroll from their Medicare Advantage plan and return to Original Medicare between January 1st and February 14th each year. Generally, the disenrollment request 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. Note: MSA plan members generally cannot disenroll and return to Original Medicare during this period. MSA members can only disenroll during AEP or a qualifying Special Election Period.

- **Special Election Period:** The election can be made at any time though depending on the SEP the member may be limited to only one election. Generally enrollment occurs the first day of the month after the month the election request is received. This can vary based upon the type of Special Election Period (see next page).

MSA Election Periods

- Individuals may enroll in a MSA plan **only** during their ICEP or AEP.
- Members may disenroll from their MSA plan only during AEP, Open Enrollment for Institutionalized Individuals (OEPI), and certain SEP's.
  - Medicaid eligibility (dual-eligible)
  - LIS eligibility
  - Medigap/Medicare Advantage Trial Period
  - Employer/Union Group Health Plan
  - Contract violations (requires CMS approval)

At a Glance Special Election Periods

CATEGORY	WHO CAN I SELL TO?	WHEN CAN I SELL IT?	INFORMATION NEEDED
Age-In's & Disability	Individuals turning 65	Begins 3 months before & ends 3 months following the month of turning 65	Part A & B effective dates (Restrictions apply if they delay Part B)
	25th month of Disability	Begins 3 months before & ends 3 months following 25th month of disability benefits	
Move-In's	Moved and • Currently lives outside service area • New plan options available • Returned to the U.S.	Begins 1 month before & ends 2 months following the month of move	Member Attestation
	Moved to or from an institution	Begins the 1st day in facility & up to 2 months after discharge	
Low Income	Dual Eligible (Full)	Medicaid eligible & have appropriate DPW program & category code	Medicaid # or Award Letter
	Part D Subsidy (LIS)	From date notified	SSA Award Letter
	PACE/PACENET	Effective enrollment date to the years end	Award Letter or ID Card
Chronic SNP	Qualifies for SNP due to diabetic or heart failure status	Upon confirmation of a condition	Eligibility Form – Signed or Member Attestation
Losing Coverage	Part D Subsidy (LIS) Terminated	From month notified to 60 days after coverage loss	SSA, Medicaid or PACE Letter
	PACE/PACENET Disenrollment	Up to 2 months after effective disenrollment date	Disenrollment Letter
	Loss of SNP status	Up to 2 months after notice is received	Loss of coverage letter
	Loss of Creditable Drug Coverage	From month notified to 60 days after coverage loss	Loss of coverage letter
	Employer/Union Group Coverage Termination	Up to 2 months after month coverage ends	Term letter from group
	Loss of Dual Eligible status	Within 3 months after loss of eligibility	State notice

* For internal use only

Year Round Sales Opportunities and Special Election Periods

- Special Needs Plan like Geisinger Gold Secure 1 are open for enrollment at any time of the year.
- **Change in Residence:** The effective date occurs the first day of the month after the month of the move or first day of the month (up to 3 months after) the date of the move (member's choice). Ex. Applicant moves from FL to PA on June 18th. MA organization receives enrollment request from the applicant in May. The applicant may choose an effective date of July 1, Aug 1 or Sept 1.
- **Employer/Union Group Health Plan (EGHP):** The applicant may choose an effective date (being the first of the month) up to 2 months after the month in which the individual loses or becomes eligible for Employer/Union group coverage.
- **Medicaid Coverage:** Does the applicant currently have or lost Medicaid coverage? - The effective date is the first day of the month after receipt of a completed election request. This SEP exists every month of the year as long as the individual is entitled to Medicaid.
- **Low Income Subsidy (LIS):** Has the applicant recently been approved for extra help with part D? - The effective date occurs the first day of the month after receipt of a completed election request. This SEP exists every month of the year as long as the individual is entitled to LIS.
- **Open Enrollment Period for Institutionalized Individuals (OEPI):** Is the applicant moving into or is he/she a current resident of an institution, such as a nursing facility or long-term care hospital? Are they moving out of such a facility? The effective date occurs the first day of the month after receipt of a completed election request. This SEP exists every month of the year as long as the individual is institutionalized. This SEP ends 2 months after the month the individual moves out of the institution.
- **Retroactive notice of Medicare entitlement:** Has the applicant recently received a notice telling them that they have been approved for Medicare for a "retroactive" date? - The enrollment period occurs no earlier than the 1st of the month in which the individual received Medicare notice and continues up to 2 additional months after the month the individual received the notice.
- **PACE/ Federal program:** Is the applicant currently enrolled in an All Inclusive Care for the Elderly Federal plan? The enrollment period occurs the first day of the month following disenrollment from the Federal program up to 2 months after the effective date of Federal program disenrollment. (Not to be confused with Pennsylvania's PACE/PACENET drug coverage.)
- **Non-renewing contracts:** Is the applicants plan ending its contract with Medicare. - Generally notice is given 90 calendar days prior to the end of the year - Beneficiaries may choose an effective date of either Jan. 1, Feb. 1 or March 1 (dates subject to change based on pending CMS guidance).

- **Involuntary Loss of creditable coverage:** Did the applicant recently involuntarily lose their creditable drug coverage. The effective date is the first of the month following a completed enrollment request with and enrollment period up to 3 months prospective after the completed request is submitted.

- **State Pharmaceutical Assistance Program (PACE/PACENET Coverage):** Does the applicant belong to a pharmacy assistance program provided by their state, or are they losing or did they recently lose participation in such a program? The effective date is the first of the following month in which a completed enrollment request is received. (Beneficiaries can only use this SEP once per calendar year.)

- **Individuals who lose LIS eligibility:** Is he 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.

- **Individuals Who Lose Special Needs Status:** Is the applicant being disenrolled from a Medicare special needs plan because they no longer have a special needs status. The effective date is the first of the following month in which the beneficiary submits a completed enrollment request.

- **Miscellaneous:** MSA individuals can only elect this plan during their ICEP and AEP (see definitions above). HMO and PPO plans can enroll/disenroll during the AEP (no restrictions apply). If an individual has a qualifying election period , outside of the AEP, that would permit them to enroll or disenroll from any Health Plan.

- **Trial Periods:** Beneficiaries enrolled in a Medicare Supplement plan who then enroll in an MA plan have a period of one year to re-enroll in a Medicare Supplement plan should they choose to disenroll from the MA plan. This re-enrollment would qualify for guaranteed issue.

Scope of Appointment Basics

Scope of Appointment Basics

When is the Scope of Appointment form required?

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

- In-home sales appointments or personal/individual appointments with an existing member/client in office, coffee shop or other similar location;
- For appointments with new members / clients (not existing members/clients); and/or
- When a plan or agent/broker sells more any type of Medicare Advantage product.

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.
- A scope of appointment form must be signed if a follow-up appointment to discuss another type of product is made after the initial appointment. The follow-up appointment must occur at least 48 hours after the initial appointment.

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)

- Please see sample Scope of Appointment Form on following pages.

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.).

Can brokers or agents selling for more than one plan use the model Scope of Appointment form for all its contracted plan sponsors?

- Since there are no organization specific details in the model Scope of Appointment form, the model form can be used by agents for multiple organizations.

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

Scope of Sales Appointment Confirmation Form

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.

☐ **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, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account 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.

Y0032 H9412 H8468 H2792 12283_4 File and Use 10/14/12

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 Medical Savings Account (MSA) Plan — MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.
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.

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'sName:*_____

Your Relationship to the 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.)	
Agent's Signature:	
Plan(s) the agent represented during this meeting:	
Date Appointment Completed:	
Plan Use Only:	

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

Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting:

Geisinger Gold is a Health plan with a Medicare contract.

Home Visit / Group Meeting Audit Checklist

Home Visit / Group Meeting Audit Checklist

- ☐ Identify yourself by name and company
- ☐ Did you make it clear that you work for a Medicare Advantage Plan
- ☐ Did appointment / meeting start on time
- ☐ Were products identified at start of meeting
- ☐ Was the Scope of Appointment completed
- ☐ Did you explain Original Medicare and how it works when enrolled in a Medicare Advantage Plan
- ☐ Did you explain when to enroll, disenroll and change plans
- ☐ Did you explain the plan premiums
- ☐ Did you explain the plan co-pays
- ☐ Did you explain the plan co-insurance
- ☐ Did you explain the plan out-of-pocket limits
- ☐ Did you explain Part D Prescription Drug coverage
- ☐ Did you explain the plan Prescription Drug pricing & tiering
- ☐ Did you show and explain the Provider Directory
- ☐ Did you show and explain how to check if drugs are covered
- ☐ Did you explain the coverage gap
- ☐ Did you explain the Network Restrictions
- ☐ Did you explain seeing out-of-network providers may result in higher cost-sharing
- ☐ Did you avoid using high pressure tactics
- ☐ Did you avoid making absolute statements
- ☐ Did you avoid using scare tactics
- ☐ Did you avoid using incorrect competitor info to close the sale
- ☐ Did you avoid discriminatory practices
- ☐ Did you avoid offering a gift for enrolling in a plan
- ☐ If a gift was offered, was the combined total $15 or less
- ☐ Did you avoid cross-selling of products
- ☐ If SNP was presented did you explain the eligibility requirements
- ☐ If SNP was presented, did you explain that any changes in eligibility may lead to disenrollment
- ☐ Did you provide appropriate marketing materials
- ☐ Did you provide only CMS approved marketing materials with a material ID

Accessories Program

Accessories Program
Valuable Discounts for Members

GEISINGER GOLD®

The Accessories Program is available to all Geisinger Gold members. All you need is your member ID card, or use the online services available. No referrals are needed. There is no charge for using the Accessories Program. Your health plan may already cover some services for which a discount is available through the Accessories Program. You should exhaust your covered benefits first before taking advantage of the Accessories Program.

What health discounts are available?

- Fitness Center Discounts – Receive a discount on memberships at participating fitness centers. See the most up-to-date list of these centers on our Web site.
- Weight Watchers® – If you're looking for help taking off a few pounds, consider joining Weight Watchers. It can teach you how to lose weight safely and keep it off through a combination of support and flexible food, activity and maintenance plans. Please see the back of this brochure for more information.

What about specialty services and products?

ChooseHealthy™ provides discounts on complementary health care services, such as:

- Chiropractic Care – Many people find chiropractic treatment to be beneficial, especially for ailments such as lower back pain and headaches originating in the neck. Receive a 25% discount off the usual fee for services from any American Specialty Health Networks chiropractor. This includes mobilization and adjustment of tissues and joints. It may also include x rays, ultrasound, cold pack treatments or electrical muscle stimulation.
- Massage Therapy – It's often used to alleviate stress and boost blood flow. Visit any ASH Networks massage therapist and receive a 25% discount on fees.
- Acupuncture – Used to treat back pains, headaches, chronic pain and neurological disorders, acupuncture is a way to modify or prevent pain. Receive a 25% discount from ASH Networks providers. Call (877) 335-2746 for more information.
- Fitness Centers – In addition to our own fitness center network, members have access to fitness centers through ASH Networks. Visit the Web for a complete list.
- Health Products – Receive a 15 to 40% discount through Choose HealthyTM, plus free standard shipping on health products, including vitamins, nutritional supplements, exercise DVDs and much more. (Products are available through ASH Networks.)

Are vision services included?

Yes. The program includes ways to cut costs on vision care products and services.

- Eyewear and Eye Exams – Get substantial savings through LensCrafters®, Target Optical, Sears Optical® and most Pearle Vision Centers®, as well as independent providers. Receive a $5 discount on routine examinations and $5 off contact lens exams. Discounts are available on eyeglass lenses, frames, coatings, tints, lens treatments, and conventional (not disposable) contact lenses.

HPM50 PA Accessories 10/12

- Mail Order Contact Lenses – You can receive replacement conventional lenses by mail. Ordering is easy, either online (www.eyemedcontacts.com) or by calling EyeMed Vision Care at (800) 508-1399. The contact lenses will be shipped directly to you. Lenses are 100% guaranteed. (Other Accessories Program discounts do not apply.)
- Laser Vision Correction – Save 15% off the regular price for LASIK and PRK treatments (or 5% off promotional prices) through U.S. Laser Network. This includes pre- and post-operative care. LASIK and PRK procedures must be performed at a LasikPlus Center to receive discounts. Pre- and post-operative care may be received from other providers, but members will be responsible for costs. Call (877) 552-7376 for more information.

If you have questions about the Accessories Program, call us today!

Current members should call the Customer Service Team at (800) 498-9731
Prospective members should call: (800) 514-0138
8:00 a.m. to 8:00 p.m.,
7 days a week, Oct. - Feb.
or 8:00 a.m. to 8:00 p.m., Mon. - Fri., March - Sept.
TDD: 711

For more information on additional discounts and recent additions to the Accessories Program, please visit and log in to the Member section at **www.GeisingerGold.com**.
Special offers on Weight Watchers programs vary by county. Members should call the Customer Service Team for more information.

ChooseHealthy is a trademark of American Specialty Health Networks, Inc. ChooseHealthy is a discount program; it is not insurance. ChooseHealthy provides discount complementary health care services from participating providers. You are obligated to pay for all health care services but will receive a discount from those health care providers who have contracted with the discount plan. ChooseHealthy does not make payments directly to participating providers in the discount plan. ChooseHealthy has no liability for providing or guaranteeing service and assumes no liability for the quality of service rendered.

The products and services described in this booklet are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the Geisinger Gold grievance process.

Should a problem arise with a value-added service, please contact the Geisinger Gold Customer Service Team.

The Accessories Program is made available solely for the convenience of those members who are interested in the discounted health items and services offered. Geisinger Health Plan and Geisinger Indemnity Insurance Company (collectively "Health Plan") do not endorse the individual practitioners, services and products of the Accessories Program and do not guarantee results or outcomes. Health Plan accepts no responsibility for loss that may arise from reliance on the services. Health Plan makes no representation or warranty about quality, suitability or fitness for a particular purpose of any product or service offered under the Program. The practitioners, services or products of the Accessories Program should not be used as a substitute for medical diagnosis and treatment. Health Plan recommends that members consult with their physician before using any health services or products pursuant to the Program.

In order to take advantage of Accessories Program discounts, members may be required to show their Member Identification Card or provide other information directly to vendors who participate in the Accessories Program. Member understands that his/her disclosure of information directly to the vendor whether in person, over-the-phone, internet or any other manner is done at their own risk and Health Plan assumes no liability relative to the member's voluntary disclosure of such information. Health Plan will not disclose member information to the vendor.

These discounts and services are not included in the Health Plan benefits plans and are provided strictly as a convenience as indicated above. This Program and any of the practitioners, services and products in the Program are not guaranteed for any length of time and may be discontinued with or without notice to members.

Sales Questions and Talking Points

Sales Questions and Talking Points

Geisinger Gold Classic 1, 3 and 4 HMO Plans

Sales Questions

- Is the beneficiary looking for plans that provide the security of fixed copays?
- Does the beneficiary find comfort in the idea of having a physician help them coordinate their care appealing?
- Does the peace-of-mind of knowing that Proven Health Navigator Medical Home is available to help navigate the healthcare system in the event they become ill sound attractive to the beneficiary?
- Is the beneficiary looking for a one-stop shopping experience?

Talking Points

- Classic offers a range of options – from Classic 1 with predictable, fixed copays to Classic 3/Classic 4 with $0 plan premiums
- Classic HMOs are Geisinger's most established plans – they have been in operation since 1995
- Over 96 hospitals and more than 40,000 providers participate in the network.
- Classic 1 covers routine office visits, annual wellness visits, immunizations, diagnostic tests and x-rays to keep you healthy. In addition, Geisinger Gold Classic 1 also covers benefits that traditional Medicare does not, like coverage towards eyeglasses, hearing aid and preventive dental benefits, Silver Sneakers fitness center coverage, routine preventive services at $0 copay, worldwide emergency room coverage and nationally accredited Health and Wellness programs. This plan also features an out of pocket maximum of $2,800 (premiums do not apply towards the annual maximum).
- Classic 3/Classic 4 feature a $0 plan premium for medical benefits. Classic 3 includes a $1,300 plan level deductible and a $2,250 out of pocket maximum. Classic 4 (offered only in Carbon, Lehigh and Northampton counties) includes a $1,600 plan level deductible and a $2,250 out of pocket maximum. The following benefits apply to the deductible:
  - Inpatient Hospital Care (includes Mental Health, Substance Abuse and Rehabilitation Services), Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility), Outpatient Services/Surgery, Ambulance Services (medically necessary ambulance services), Prosthetic Devices (includes braces, artificial limbs and eyes, etc.), Diagnostic Tests, X-Rays, Lab Services, and Radiology Services, End-Stage Renal Disease, Medicare –covered Dental Services, Blood.

Geisinger Gold Classic Plus HMO-POS Plan

Sales Questions

- Does the beneficiary find the comfort and security of coordinated care with the ability to use out-of-network providers appealing?
- Is having a plan with premium under $100/month combined with coverage featuring lower copays and less coinsurance attractive?

- Does the beneficiary travel occasionally but primarily remains within the service area?

Talking Points

- With Geisinger Gold Classic Plus, beneficiaries should select a primary care physician, they can take advantage of the quality and benefits that Geisinger coordinated care provides with the flexibility to use providers that are not in the network.
- Services provided in-network offer lower cost sharing and referrals are not required. Referrals are not required for services provided out of network, but cost sharing may be higher.
- Classic Plus has a $0 deductible (both in and out-of-network). This plan features a predictable $125 a day inpatient copay for the first five days when in-network, fixed $10/$25 copays for PCP/Specialist visits in-network and $15/$30 out-of-network (most other benefits covered at 20%). The plan offers coverage of preventive dental benefits, eyeglasses, hearing aids, Silver Sneakers fitness center coverage, $0 annual wellness exams, routine preventive services at $0 copay and nationally accredited Health and Wellness programs.

Geisinger Gold Preferred 1 and Preferred 3 PPO Plans

Sales Questions

- Does the beneficiary travel frequently? When they travel, is it for extended periods of time (but less than 183 days out of the Service Area)?
- Does the beneficiary want the quality and value that Geisinger Gold provides even though one or more of their providers may not participate in our network?
- Does the beneficiary want the flexibility to seek care out-of-network for routine services?
- Does the beneficiary want the peace of mind of paying predictable fixed copays for office visits out-of-network?
- Does the beneficiary want access to a plan with no referrals required?

Talking Points

- Though the beneficiary will pay less cost sharing by seeing providers within the network, they'll have the option to see any provider who accepts Medicare and our PPO. They will have coverage for routine office visits out of the area).
- Preferred 1 features a $195 plan level deductible (in & out of network combined). Preferred 3 (available in Carbon, Lehigh and Northampton counties only) features a $120 plan level deductible (in & out of network combined). For only those benefits that apply to deductible, coverage will not be offered until the deductible is satisfied. For example, with Preferred 1, if a member requires lab work in January that costs $100 and additional lab work in March that costs $50, they have paid $150 out-of-pocket. They would be responsible for another $45 in benefits/services before the deductible is satisfied. Your deductible is applied to your plan out-of-pocket maximum (premiums do not apply towards the annual out-of-pocket maximum).

Geisinger Gold Preferred 2 PPO Plan

Sales Questions

- Does the beneficiary travel frequently? When they travel, is it for extended periods of time (but less than 6 months out of the Service Area)?
- Is the beneficiary looking for a plan that offers additional benefits like routine eye wear, hearing aids, routine dental services and a fitness benefit?
- Is the beneficiary looking for a mid-priced plan that offers moderate cost sharing and valuable extras backed by the quality of Geisinger?
- Is the beneficiary looking for a plan without a referral requirement?

Talking Points

- You can go to any doctor or hospital in the network as well as physicians and hospitals not in the network (higher cost sharing may apply.) No referrals are necessary in or out of the network. Plus, we cover the same services as traditional Medicare plus several additional benefits.
- Preferred 2 features a $100 plan level deductible (in & out of network combined). For only those benefits that apply to deductible, coverage will not be offered until the deductible is satisfied. The plan features $20/$35 copays for PCP and Specialist doctor's visits in-network after the deductible is met and $30/$45 copays out-of-network after the deductible is met.

Geisinger Gold Reserve MSA Plan

Sales Questions

- Does the beneficiary want maximum flexibility to control the direction of their health care?
- Is the beneficiary looking for a plan without a network of providers or referral requirement?
- Is the beneficiary comfortable managing their own healthcare finances?
- Has the beneficiary had a Health Savings Account or Health Reimbursement Arrangement through a former employer?

Talking Points

- Geisinger Gold Reserve is a Medicare Advantage plan, but it is different from traditional plans like health maintenance organizations (HMO) or preferred provider organizations (PPO). Geisinger Gold Reserve does not require the use of a network of medical providers. The beneficiary can go to any doctor, hospital or health care facility that accepts Medicare and Geisinger Gold's terms and conditions of payment. Combining key features -- $0 monthly premiums, a contribution (deposit) to a personal medical savings account and open access to physicians -- make Reserve unique. This is the only Medicare coverage that allows the beneficiary to manage the way they use and pay for your health care.
- $0 monthly plan premium.
- Geisinger Gold provides contribution/deposit every year to help pay the deductible.

- The beneficiary can use the deposit to cover qualified, Medicare-covered health care services, such as doctor visits, getting a mammogram, going to a chiropractor, etc.
- After the annual deductible is met, beneficiaries have 100% coverage for Medicare-covered medical expenses. That means no additional out-of-pocket expenses for your Medicare-covered, medically necessary services.
- Beneficiaries can go to any doctor or medical facility that accepts Medicare and is willing to bill Geisinger Health Plan (Geisinger pays the same as Medicare to providers)
- Beneficiaries can use the funds to pay for some expenses that Original Medicare and a Medicare Supplement plan do not cover, such as routine physicals, hearing aids, eye wear, dental expenses, immunizations and mammograms. However, those expenses will not apply to the plan level deductible.
- Money left over in the beneficiary's account rolls over to the next year.
- The deposit is 'triple tax free', meaning the funds are not taxed when deposited, not taxed when withdrawn from the account and not taxed at the end of the year as long as they are spent on IRS Qualified Medical Expenses (see IRS publication 502 on www.IRS.gov)

Geisinger Gold Secure 1 HMO SNP (for Dual-Eligible beneficiaries)

Sales Questions

- Is the beneficiary eligible for both Medicare and Medicaid?
- Does coverage for over the counter drugs interest the beneficiary?
- Would the beneficiary like to pay $0 plan premium and reduced, if any, copays for most services?
- Does the beneficiary currently have a yellow and green ACCESS card through the State of PA?
- Is the beneficiary part of the Health Choices program?
- Are you looking for a plan with year-round enrollment opportunities?

Talking Points

- Secure 1 is designed for people who are fully eligible for both Medicare and Medicaid benefits currently. Members' premiums are paid in part or in full by the health plan. In addition, PA Medical Assistance generally wraps around the Medicare benefit resulting in virtually NO out-of-pocket expense to the member. The Secure 1 plan provides prescription drug coverage. There is also a benefit of $50 per quarter for over the counter medicines. A Class 1 dental benefit with up to $800 allowance is included too (e.g. cleaning/exams, x-rays, crowns and fillings.)

In addition, all plans feature:

- Both injectable and non-injectable drugs that are covered under your Medicare Part B (not Part D) apply to the service specific out-of-pocket maximum.
- Cost sharing for outpatient therapies (physical therapy, speech therapy and occupational therapy) and lab/radiology services (e.g. x-rays, MRI/CAT/PET/CT scans) is charged per visit, not per unique service.
- Routine dental cost sharing that does not apply to the plan-level out of pocket maximum.

Online Broker Resources

Online Broker Resources

Geisinger Gold Broker Portal

www.geisingergold.com/broker

Welcome to the Geisinger Gold Broker Portal. Here you can register and start the contracting process if you're new to Geisinger Gold. If you're a returning agent, you can log-in with your username and password to access Product Training, Geisinger Gold 101, or order Marketing and Sales Materials.

Once you have registered and signed in with your username and password, selecting **Contracting** will start the process for you. Click **I am new to Geisinger Gold** to see the documents required to get contracted. If you're an existing agent and need to take your AHIP/Product Training for the year go to **I am updating my appointment for this year**.

The Product Training portion of the Portal gives you access to the **Quick Reference Guides**, which is a great tool to use during your product training tests, as well as in the field as a sales tool to refer to for specific information on all Geisinger Gold Plans and more. Just remember, this tool is for Agents only, it is **NOT** approved for Beneficiary use. To begin your **Product Training**, click the link at the bottom of the page.

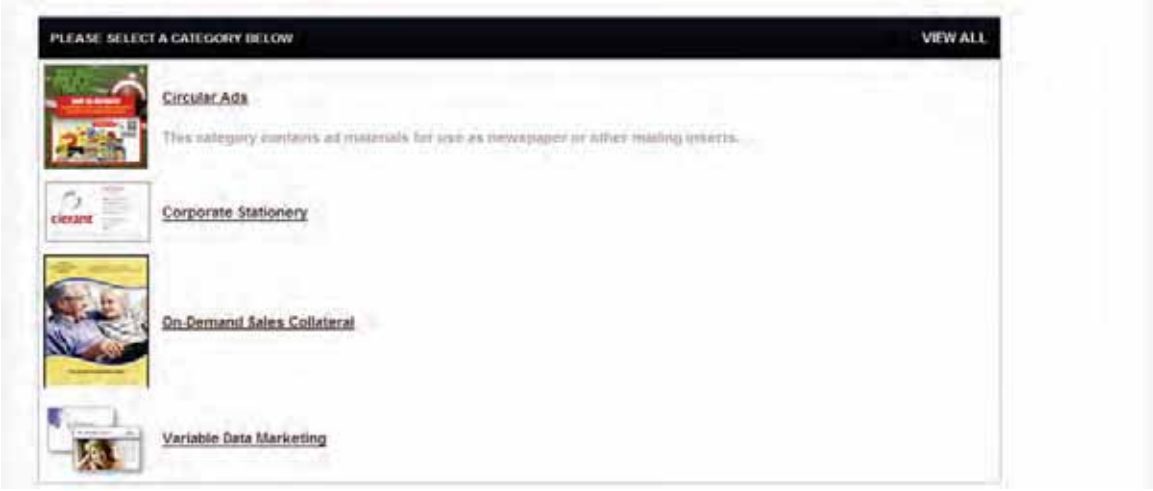
Once you are appointed and certified to sell Geisinger Gold, you will gain exclusive access to **Geisinger Gold 101**, which allows you to go through in-depth trainings on everything from Industry updates and compliance to sales and in-depth product training. You can easily customize your next marketing campaign and order sales kits through our new **Marketing & Sales Materials** site. Please don't hesitate to **Contact Us** if you have any questions or issues.

Ordering Marketing Collateral

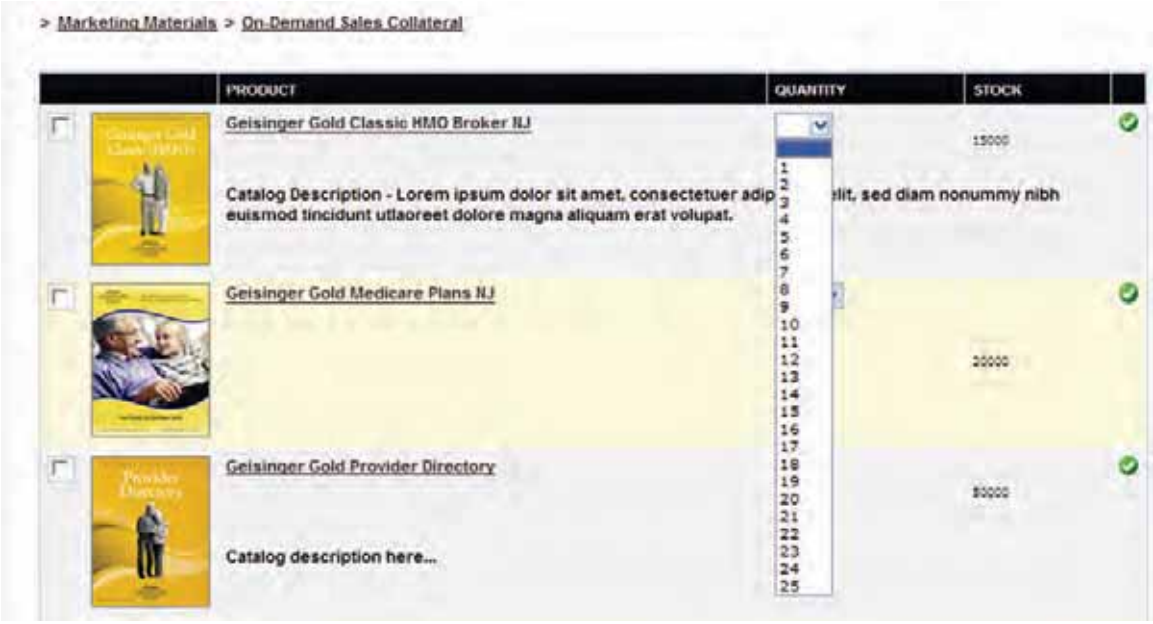
The Geisinger Gold Broker Portal will link to the online collateral ordering system. Registered users of the broker portal will click through without additional sign in required. Some users may need to register and sign in, especially if you access the ordering portal Website directly.

Click on **Products** to get started.

Select **On Demand Sales Collateral**.

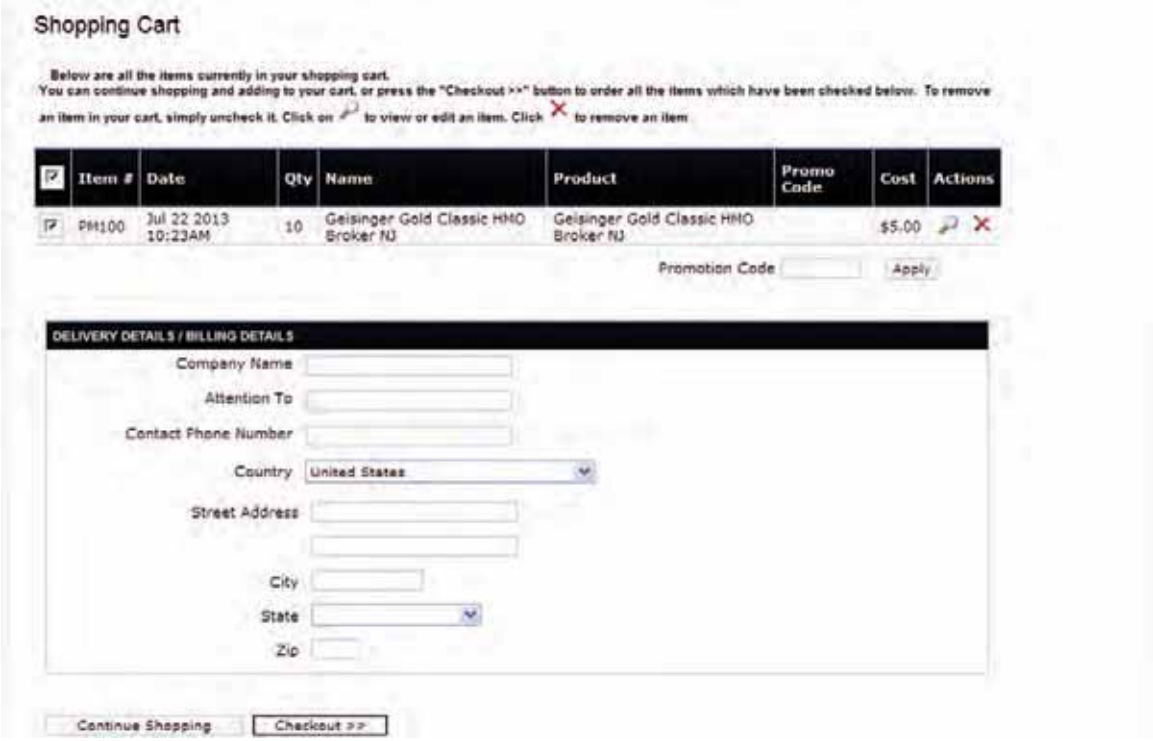


Select the item you wish to order and the quantity.

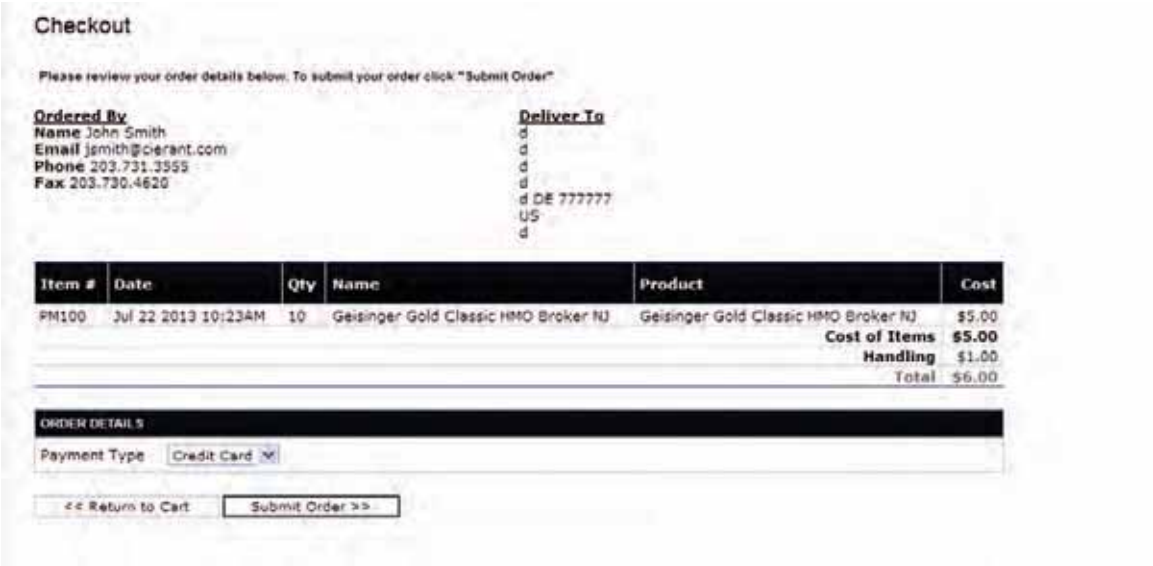


Click **Add to Cart** or **Add to Cart and Checkout**

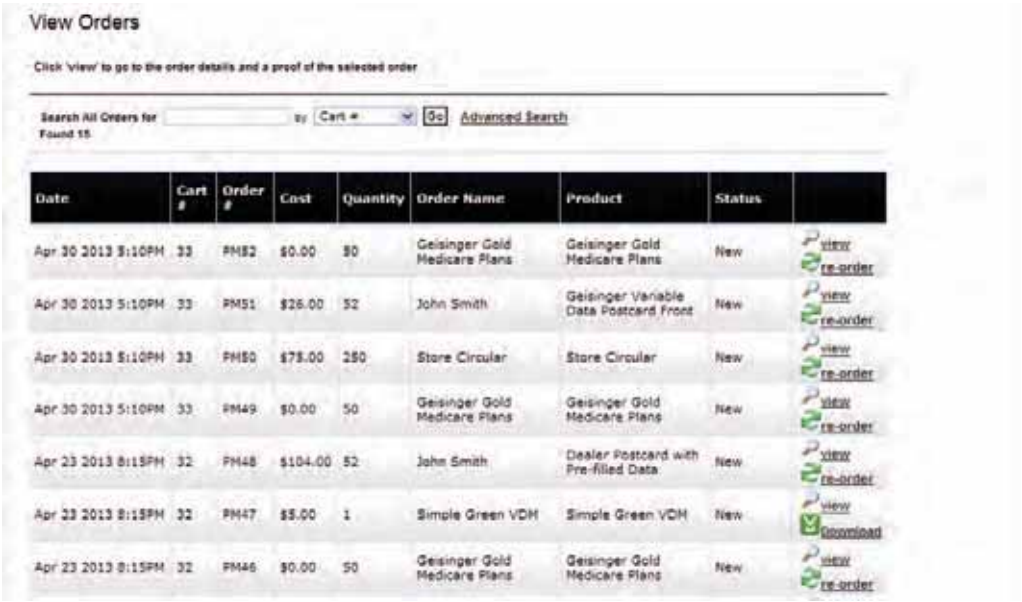
Confirm your items and enter delivery information in the shopping cart. Please note: Most sales collateral items (such as enrollment kids and benefit overview booklets) have no cost. Future offerings, such as custom post cards or letter may carry a cost to the agent.



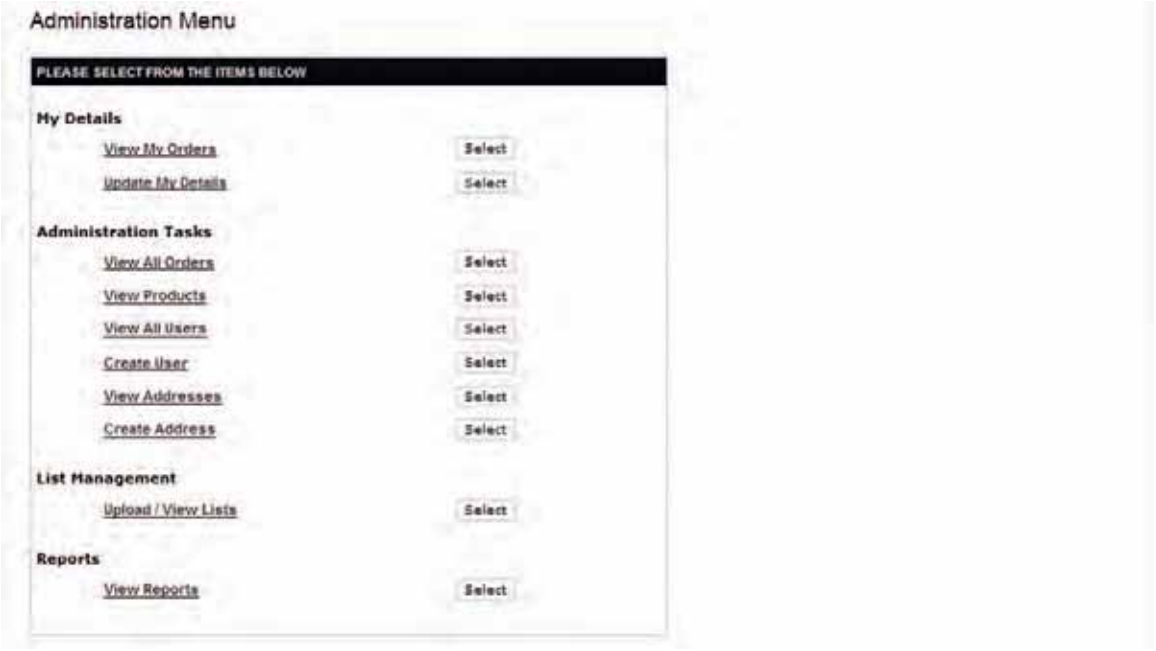
Confirm order and select **Submit Order**.



Click on **Orders** to view your order history.



Click on **Admin** to view or update your profile information, delivery information and more.



Broker Advertising and Document Approval

Broker Advertising and Document Approval

The following process must be followed for Geisinger Health Plan to permit advertising of the broker's intent to sell on behalf of Geisinger Health Plan.

- Ad copy is sent to Key Account Representative's office.
- Key Account Rep reviews copy and ensures contract is valid and in place and forwards to Marketing.
- Key Account Rep calls marketing to inform them about the request and to provide any other pertinent information.
- A marketing staff person receives the document and reviews it for accuracy, use of name, logo and likeness, as well as representation of benefits, limitations and exclusions.
- A marketing staff person signs off on the document after making appropriate corrections and either:
- Calls broker directly to discuss changes to see if they could be controversial, or
- Provides changes and faxes directly back to the broker.
- After approval or changes are made, Key Account Rep is notified via fax.
- Both Key Account Rep and Marketing retain a copy of the change and notated ad, as well as a copy of the final ad as it actually appeared in the publication or document.
- Key Account Rep assures the broker understands that all documents going to the public, employers, newspapers or professional organizations receive prior written approval by Marketing before use.
- The use of our name, logo or likeness in advertising without the express written permission of the Health Plan's Marketing and Sales Departments will serve as cause for a written warning and possible termination of contract.


GEISINGER
GOLD®