

**GEISINGER GOLD**



## **2024 Summary of Benefits**

**Geisinger Gold Preferred Advantage Rx (PPO)**

H3924, Plan 059 S22

Jan. 1 – Dec. 31, 2024

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

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

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

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

Our service area includes these counties in Pennsylvania: Adams, Berks, Bucks, Carbon, Chester, Cumberland, Dauphin, Franklin, Lancaster, Lebanon, Lehigh, Monroe, Northampton, Perry, and York.

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

If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at <https://www.medicare.gov> or get a copy by calling 1-800-MEDICARE (1800-633-4227), 7 days a week, 24 hours a day. TTY users should call 1-877-486-2048.

	<b>Geisinger Gold Preferred Advantage Rx (PPO)</b>
<b>Monthly Plan Premium</b> <i>(includes both medical and drugs)</i>	\$79
<b>Deductible</b>	No deductible for medical.
<b>Maximum out-of-pocket amount</b> <i>(does not include Part D prescription drugs)</i>	From network providers: \$4,000 From network and out-of-network providers combined: \$4,000
<b>Inpatient Hospital coverage*</b>	<p><b>In-Network</b> \$200 copayment each day for days 1 to 6 and \$0 copayment each day for days 7 to 90 for Medicare-covered hospital care. \$0 copayment for additional Medicare-covered days.</p> <p><b>Out-of-Network</b> \$200 copayment each day for days 1 to 6 and \$0 copayment each day for days 7 to 90 for Medicare-covered hospital care. Cost-sharing will not exceed \$1,200 annually for Medicare-covered inpatient hospital care In and Out of network combined.</p>
<b>Outpatient Hospital coverage*</b>	
Outpatient hospital services	<p><b>In-Network</b> \$0 - \$250 copayment</p> <p><b>Out-of-Network</b> \$0 - \$250 copayment</p>
Outpatient hospital observation services	<p><b>In-Network</b> \$0 - \$250 copayment per day</p> <p><b>Out-of-Network</b> \$0 - \$250 copayment</p>
<b>Ambulatory Surgical Center (ASC)*</b>	<p><b>In-Network</b> \$0 - \$250 copayment</p> <p><b>Out-of-Network</b> \$0 - \$250 copayment</p>

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	<b>Geisinger Gold Preferred Advantage Rx (PPO)</b>
<b>Doctor Visits</b> Primary Care Providers  Specialists	<b>In-Network</b> \$10 copayment  <b>Out-of-Network</b> \$10 copayment  <b>In-Network</b> \$25 copayment  <b>Out-of-Network</b> \$25 copayment
<b>Preventive Care (e.g., flu vaccine, diabetic screenings)</b>	<b>In-Network</b> \$0 copayment  <b>Out-of-Network</b> \$0 copayment
<b>Emergency care</b>	\$120 copayment Copayment is waived if you are admitted to a hospital within 3 days for the same condition.
<b>Urgently needed services</b>	\$25 copayment Copayment is waived if you are admitted to a hospital within 3 days for the same condition.
<b>Diagnostic Services/Labs/Imaging*</b> Diagnostic tests and procedures  Lab services	<b>In-Network</b> \$15 copayment  <b>Out-of-Network</b> \$15 copayment  <b>In-Network</b> \$15 copayment  <b>Out-of-Network</b> \$15 copayment

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	<b>Geisinger Gold Preferred Advantage Rx (PPO)</b>
<p>Diagnostic radiology services (e.g. MRI, CAT Scan)</p> <p>Outpatient X-rays</p> <p>Therapeutic Radiology</p>	<p><b>In-Network</b> \$30 - \$275 copayment</p> <p><b>Out-of-Network</b> \$30 - \$275 copayment</p> <p><b>In-Network</b> \$30 copayment</p> <p><b>Out-of-Network</b> \$30 copayment</p> <p><b>In-Network</b> \$30 - \$60 copayment</p> <p><b>Out-of-Network</b> \$30 - \$60 copayment</p>
<p><b>Hearing services</b></p> <p>Exam to diagnose and treat hearing and balance issues</p>	<p><b>In-Network</b> \$25 copayment</p> <p><b>Out-of-Network</b> \$25 copayment</p>
<p><b>Dental Services*</b></p>	<p><b>In-Network</b> \$25 copayment for each Medicare-covered service.</p> <p><b>Out-of-Network</b> \$25 copayment for each Medicare-covered service. <i>Referral may be required.</i></p>
<p><b>Vision care</b></p> <p>Exam to diagnose and treat diseases and conditions of the eye</p>	<p><b>In-Network</b> \$0 - \$25 copayment</p> <p><b>Out-of-Network</b> \$0 - \$25 copayment</p>

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	<b>Geisinger Gold Preferred Advantage Rx (PPO)</b>
<p>For people with diabetes, screening for diabetic retinopathy is covered once per year.</p> <p>Eyewear after cataract surgery</p> <p>Glaucoma screening</p>	<p><b>In-Network</b> \$0 - \$25 copayment</p> <p><b>Out-of-Network</b> \$0 - \$25 copayment</p> <p><b>In-Network</b> \$0 copayment</p> <p><b>Out-of-Network</b> \$0 copayment</p> <p><b>In-Network</b> \$0 copayment</p> <p><b>Out-of-Network</b> \$0 copayment</p>
<p><b>Mental Health Services*</b></p> <p>Inpatient visit</p> <p>Outpatient group therapy visit</p>	<p><b>In-Network</b> \$200 copayment each day for days 1 to 6 and \$0 copayment each day for days 7 to 90 for Medicare-covered hospital care. \$0 copayment for an additional 60 lifetime reserve days.</p> <p><b>Out-of-Network</b> \$200 copayment each day for days 1 to 6 and \$0 copayment each day for days 7 to 90 for Medicare-covered hospital care. Cost-sharing will not exceed \$1,200 annually for Medicare-covered care In and Out of Network combined.</p> <p><b>In-Network</b> \$5 copayment</p> <p><b>Out-of-Network</b> \$5 copayment</p>

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	<b>Geisinger Gold Preferred Advantage Rx (PPO)</b>
Outpatient individual therapy visit	<p><b>In-Network</b> \$10 copayment</p> <p><b>Out-of-Network</b> \$10 copayment</p>
<b>Skilled nursing facility*</b>	<p><b>In-Network</b> \$0 copayment each day for days 1 to 20, \$160 copayment each day for days 21 to 45, and \$0 copayment each day for days 46 to 100 for Medicare-covered skilled nursing facility care.</p> <p><b>Out-of-Network</b> \$0 copayment each day for days 1 to 20, \$160 copayment each day for days 21 to 45, and \$0 copayment each day for days 46 to 100 for Medicare-covered skilled nursing facility care.</p>
<b>Physical Therapy*</b>	<p><b>In-Network</b> \$25 copayment</p> <p><b>Out-of-Network</b> \$25 copayment</p>
<b>Ambulance services</b>	
Ground Ambulance	<p><b>In-Network</b> \$200 copayment (waived if admitted)</p> <p><b>Out-of-Network</b> \$200 copayment (waived if admitted)</p>
Air Ambulance	<p><b>In-Network</b> \$200 copayment</p> <p><b>Out-of-Network</b> \$200 copayment</p>

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	<b>Geisinger Gold Preferred Advantage Rx (PPO)</b>
<b>Transportation Services</b>	<p><b>In-Network</b> <u>Not covered</u></p> <p><b>Out-of-Network</b> <u>Not covered</u></p>
<p><b>Medicare Part B prescription drugs*</b></p> <p>Chemotherapy/Radiation drugs</p> <p>Other Part B drugs</p>	<p><b>In-Network</b> 0% - 20% coinsurance</p> <p><b>Out-of-Network</b> 0% - 20% coinsurance</p> <p><b>In-Network</b> 0% - 20% coinsurance; Insulin capped at \$35</p> <p><b>Out-of-Network</b> 0% - 20% coinsurance; Insulin capped at \$35</p>

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**Additional Benefits**

	<b>Geisinger Gold Preferred Advantage Rx (PPO)</b>
<b>Annual routine physical exam</b>	<p><b>In-Network</b> \$10 copayment</p> <p><b>Out-of-Network</b> \$10 copayment</p>
<p><b>Chiropractic services</b></p> <p>We cover only manual manipulation of the spine to correct subluxation</p>	<p><b>In-Network</b> \$20 copayment</p> <p><b>Out-of-Network</b> \$20 copayment</p>
<b>Diabetic monitoring supplies*</b>	<p><b>In-Network</b> 0% - 20% coinsurance</p> <p><b>Out-of-Network</b> 0% - 20% coinsurance</p>
<b>Diabetic therapeutic shoes or inserts*</b>	<p><b>In-Network</b> 20% coinsurance</p> <p><b>Out-of-Network</b> 20% coinsurance</p>
<b>Durable medical equipment (DME) and related supplies*</b>	<p><b>In-Network</b> 20% coinsurance</p> <p><b>Out-of-Network</b> 20% coinsurance</p>
<b>Home health agency care*</b>	<p><b>In-Network</b> \$0 copayment</p> <p><b>Out-of-Network</b> \$0 copayment</p>

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	<b>Geisinger Gold Preferred Advantage Rx (PPO)</b>
<b>Hospice</b>	\$0 copayment
<b>Nursing hotline</b>	<b>In-Network</b> \$0 copayment  <b>Out-of-Network</b> \$0 copayment
<b>Opioid treatment program services*</b>	<b>In-Network</b> 20% coinsurance  <b>Out-of-Network</b> 20% coinsurance
<b>Outpatient diagnostic tests and therapeutic services and supplies*</b>	<b>In-Network</b> \$30 - \$60 copayment  <b>Out-of-Network</b> \$30 - \$60 copayment
<b>Outpatient rehabilitation services*</b> Services provided by an occupational therapist	<b>In-Network</b> \$25 copayment  <b>Out-of-Network</b> \$25 copayment
<b>Outpatient substance abuse services*</b>	<b>In-Network</b> \$10 copayment for each Medicare-covered Individual Session.  \$5 copayment for each Medicare-covered Group Session.  <b>Out-of-Network</b> \$5 - \$10 copayment

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	<b>Geisinger Gold Preferred Advantage Rx (PPO)</b>
<b>Partial hospitalization services for mental health*</b>	<p><b>In-Network</b> \$55 copayment per day</p> <p><b>Out-of-Network</b> \$55 copayment per day</p>
<p><b>Podiatry services</b></p> <p><b>Additional routine foot care</b></p>	<p><b>In-Network</b> \$25 copayment</p> <p><b>Out-of-Network</b> \$25 copayment</p> <p><b>In-Network</b> \$0 copayment</p> <p><b>Out-of-Network</b> \$0 copayment Limited to 4 visit(s) every year combined in and out-of-network</p>
<b>Prosthetic devices and related supplies*</b>	<p><b>In-Network</b> 20% coinsurance</p> <p><b>Out-of-Network</b> 20% coinsurance</p>
<b>Pulmonary rehabilitation services</b>	<p><b>In-Network</b> \$15 copayment</p> <p><b>Out-of-Network</b> \$15 copayment</p>
<p><b>Services to treat kidney disease</b></p> <p>Dialysis Services</p>	<p><b>In-Network</b> 10% - 20% coinsurance</p> <p><b>Out-of-Network</b> 20% coinsurance</p>

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	<b>Geisinger Gold Preferred Advantage Rx (PPO)</b>
<b>Welcome to Medicare preventive visit</b>	<b>In-Network</b> \$0 copayment  <b>Out-of-Network</b> \$0 copayment
<b>Worldwide Emergency Coverage</b>	\$120 copayment
<b>Worldwide emergency transportation</b>	\$200 - \$1,000 copayment
<b>Worldwide urgent care coverage</b>	\$25 copayment
<b>Geisinger Gold Health+</b>	\$38 premium

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<b>Prescription Drug Coverage</b>	<b>Geisinger Gold Preferred Advantage Rx (PPO)</b>
<b>Stage 1: Annual Prescription Deductible</b>	
<b>Deductible</b>	This plan has no deductible for Part D drugs, this payment stage doesn't apply.
<b>Stage 2: Initial Coverage (after you pay your deductible, if applicable) until total yearly drug costs reach \$5,030</b>	
<b>Standard Retail cost-sharing (30-day supply)</b>	
<b>Tier 1</b> (Preferred Generic)	\$3 copayment
<b>Tier 2</b> (Generic)	\$20 copayment
<b>Tier 3</b> (Preferred Brand)	\$47 copayment
<b>Tier 4</b> (Non-Preferred Drug)	\$100 copayment
<b>Tier 5</b> (Specialty Tier)	33% coinsurance
<b>Tier 6</b> (Vaccines Tier)	\$0 copayment
<b>Mail-order cost sharing (up to a 100-day supply)</b>	
<b>Tier 1</b> (Preferred Generic)	\$0 copayment
<b>Tier 2</b> (Generic)	\$0 copayment
<b>Tier 3</b> (Preferred Brand)	\$70.50 copayment
<b>Tier 4</b> (Non-Preferred Drug)	\$150 copayment
<b>Tier 5</b> (Specialty Tier)	Not Available
<b>Tier 6</b> (Vaccines Tier)	\$0 copayment

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

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

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

### Geisinger Gold Health+

Geisinger Gold Health+ is an optional supplemental benefits package available for purchase if you are enrolled in Preferred Advantage Rx (PPO).

Premium : \$38 per month	
Dental	<ul style="list-style-type: none"> <li>• \$1,000 max benefit per year that includes:             <ul style="list-style-type: none"> <li>○ 2 routine exams per year (with or without cleaning)</li> <li>○ 1 set of X-rays per year (bitewing or panoramic)</li> <li>○ Simple fillings, simple extractions, dentures, crowns and root canals</li> <li>○ See any provider who is approved by Medicare</li> </ul> </li> </ul>
Vision	<ul style="list-style-type: none"> <li>• \$20 copay</li> <li>• 1 routine exam per year</li> <li>• \$150 hardware allowance per year (contacts, glasses, lenses, frames)</li> <li>• See any provider who is approved by Medicare</li> </ul>
Hearing	<ul style="list-style-type: none"> <li>• \$0 copay</li> <li>• 1 routine exam per year</li> <li>• \$500 hearing aid &amp; fitting allowance per year</li> <li>• See any provider who is approved by Medicare</li> </ul>
Fitness	<ul style="list-style-type: none"> <li>• \$90 allowance per quarter for fitness center membership fees and exercise classes</li> </ul>



## **Pre-Enrollment Checklist**

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

### **Understanding the Benefits**

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

### **Understanding Important Rules**

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

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