

Classic 1 (HMO)

A traditional HMO plan. Covers routine office visits, physicals, immunizations, diagnostic tests and x-rays. Coverage for eyeglasses, hearing aids, preventive dental benefits, toe-nail trimmings and fitness center memberships are included. Copays and cost-sharing apply. Part D prescription drug coverage is available with this plan.

Classic 2 (HMO)

A traditional HMO plan. The monthly premium is lower than Classic 1. Covers provider office visits and some routine services with a copay. In addition, member would pay 15% of most other services up to a maximum of \$2,000 per year (premiums do not apply towards the annual maximum). Coverage for eyeglasses, hearing aids, preventive dental benefits, toe-nail trimmings and fitness center memberships are included. Part D prescription drug coverage is available with this plan.

Classic 3 (HMO)

A traditional HMO plan. A zero-dollar premium plan. Member pays a copay for services such as Primary Care and Specialist doctor visits, rehab, ER, home health and partial hospitalization. For other covered services, this plan pays the first \$500. Member then pays the next \$1,500 as a deductible. After that, services that are applied to the deductible are covered in full. Coverage for eyeglasses, hearing aids, preventive dental benefits, toe-nail trimmings and fitness center memberships are included. Part D prescription drug coverage is available with this plan.

Open (PFFS)

Open 2, Open 3, and Open 5 are private fee-for-service plans. Member can go to any doctor or hospital that accepts Medicare and the plan's terms and conditions. No referrals are necessary. Copays and cost-sharing apply. Part D prescription drug coverage is included with Open 2 and Open 3. Coverage for certain services varies for each plan.

Preferred (PPO)

Preferred is a PPO plan option that has in- and out-of-network coverage. No Primary Care Physician selection or referrals are required with this plan. This plan features \$0 inpatient hospital stays. Coverage for eyeglasses, hearing aids, preventive dental benefits, toe-nail trimmings and fitness center memberships are included. Part D prescription drug coverage is available with this plan.

Secure 1 (SNP)

Designed for people who are eligible for Medicare Part A, enrolled in Part B and have Medicaid coverage. Gold Secure 1 offers all the same coverage as traditional Medicare, and the member pays no premium. Secure 1 also includes Part D prescription drug coverage, dental benefits of up to \$600 per year (which include cleanings, simple fillings and simple extractions) and coverage for over-the-counter medications and medical supplies (up to \$40 per calendar quarter).

Secure 2 (SNP)

A zero-dollar premium HMO plan designed for Medicare beneficiaries who continuously reside or are expected to continuously reside for 90 days or more in a long-term care facility. Minimal copays and cost-sharing apply. Prescription drug coverage, as well as coverage for eyeglasses, hearing aids, toe-nail trimmings and routine medical transportation, are included with this plan.

Reserve (MSA)

A Medicare Advantage health insurance plan that links to a personal Medical Savings Account to help pay for medical expenses. As part of the enrollment process, the Health Plan deposits \$1,260 or \$1,500 (depending on plan) directly into a personal Medical Savings Account. Reserve plans have deductibles of \$3,000, \$4,000 or \$5,000, but no monthly premium. Member can go to any doctor or hospital that accepts Medicare and agree to see them. 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 care. Expenses incurred for Medicare-covered services go toward the annual deductible. At the end of the calendar year, if any money is left in the personal Medical Savings Account, that money will roll over for use during the next year. This plan does not include prescription drug coverage. Members may add prescription drug coverage by joining a Medicare prescription drug plan, such as one of the Geisinger Gold Rx stand-alone plans, at a separate cost.

Prescription drug coverage is included (at no additional cost) or available (for an additional monthly cost) with all plans except Reserve and Open 5. Members in those plan can enroll in our stand-alone PDP (Gold Rx).

Classic HMO

PCP selection, referrals for specialty care and network providers required

	Classic 1	Classic 2	Classic 3**
Premium	\$55-\$110	\$20-\$55	\$0
General Provisions			
Deductible	\$0	\$0	\$1,500
Coinsurance After Deductible	N/A	N/A	0%
OOP Maximum	None	\$2,000	None
Hospital Inpatient			
Non-Mental Health	\$50 per day (days 1-5)	15%	\$0 after deductible is met
Mental Health	\$50 per day (days 1-5)	\$50 per day (days 1-5)	\$50 per day (days 1-5)
SNF	\$25 per day (days 11-100)	15%	\$0 after deductible is met
Home Health Care	\$0	\$0	\$0
Hospital Outpatient			
Emergency Room	\$50	\$50	\$50
Ambulatory Surgical Center	\$0-\$50	15%	\$0 after deductible is met
Outpatient Hospital Surgery	\$0-\$50	15%	\$0 after deductible is met
Radiology - General (x-rays)	\$15	\$15	\$0 after deductible is met
Radiology - MRI/CAT/PET	\$75	15%	\$0 after deductible is met
Physical/Occupational/Speech Therapy	\$10	\$10	\$10
Preventive Screening Services	\$0	\$0	\$0
Physician			
PCP Visits	\$10	\$10	\$10
Specialist Visits	\$20	\$20	\$20
Chiropractor	\$20	\$20	\$20
Podiatrist	\$20	\$20	\$20
Psych Serv (Ind/Grp)	\$25/\$10	\$25/\$10	\$25/\$10
Sub. Abuse (Ind/Grp)	\$25/\$10	\$25/\$10	\$25/\$10
Other			
Medicare Part B Covered Drugs	10%	15%	\$0 after deductible is met
Ambulance	\$50	\$50	\$0 after deductible is met
DME / Supplies / Diabetic Monitoring	10%	15%	\$0 after deductible is met
Prosthetics	\$0	15%	\$0 after deductible is met
Immunizations	Covered	Covered	Covered in Full
Vision Exams	\$20 (one per year)	\$20 (one per year)	\$20 (one per year)
Vision Hardware Reimbursement	\$200 every two years	\$200 every two years	\$200 every two years
Hearing/Speech Exams	\$20 (one per year)	\$20 (one per year)	\$20 (one per year)
Hearing Aids Reimbursement	\$800 every three years*	\$800 every three years*	\$800 every three years*
Routine Physical Exams (1/yr)	\$10	\$10	\$10
Fitness Center	Covered in Full	Covered in Full	Covered in Full
Preventive Dental	\$20 exam, two per year; \$20-\$30 X-rays	\$20 exam, two per year; \$20-\$30 X-rays	\$20 exams, two per year; \$20-\$30 X-rays

*\$500 every three years with plans with \$0 Deductible Rx

**\$500 initial coverage (member pays nothing for first \$500 of covered services)

Refer to Provider Service Center to verify benefits and cost sharing

Open PFFS

PCP selection, referrals for specialty care and network providers not required

	Open 2*	Open 3*	Open 5
Premium	\$51-\$139.20	\$0-\$74	\$0-\$82
General Provisions			
Deductible	N/A	N/A	N/A
Coinsurance After Deductible	N/A	N/A	N/A
OOP Maximum	\$3,000	\$3,000	\$3,000
Hospital Inpatient			
Non-Mental Health	\$175 per admission	\$200 per day (Days 1-5)	\$300 per admission
Mental Health	\$175 per admission	\$200 per day (Days 1-5)	\$300 per admission
SNF	\$50 per day (days 21-100)	\$0 per day Days 1 - 3, \$65 per day Days 4 - 100	\$0 per day Days 1 - 3, \$65 per day Days 4 - 100
Home Health Care	\$10	\$20	\$20
Hospital Outpatient			
Emergency Room	\$50	\$50	\$50
Ambulatory Surgical Center	\$50	\$200	\$200
Outpatient Hospital Surgery	\$100	\$375	\$375
Radiology - General (x-rays)	\$20	\$25	\$25
Radiology - MRI/CAT/PET	\$75	20%	20%
Pathology	\$20	20%	20%
Physical/Occupational/Speech Therapy	\$15	\$25	\$25
Preventive Screening Services	\$0	\$0	\$0
Physician			
PCP Visits	\$15	\$15	\$15
Specialist Visits	\$25	\$30	\$30
Urgent Care	\$50	\$50	\$50
Chiropractor	\$25	\$30	\$30
Podiatrist	\$25	\$30	\$30
Psych Serv (Ind/Grp)	50%	50%	50%
Sub. Abuse (Ind/Grp)	50%	50%	50%
Other			
Medicare Part B Covered Drugs	20%	20%	20%
Ambulance	\$100	\$100	\$100
DME / Supplies / Diabetic Monitoring	20%	20%	20%
Prosthetics	20%	20%	20%
Immunizations	Covered	Covered in Full	Covered
Vision Exams	\$25 (one per year)	\$30 (one per year)	\$30 (one per year)
Vision Hardware Reimbursement	\$200 every two years	Not Covered	\$200 every two years
Hearing/Speech Exams	\$25 (one per year)	\$30 (one per year)	\$30 (one per year)
Hearing Aids Reimbursement	\$800 every three years	Not Covered	\$800 every three years
Routine Physical Exams (1/yr)	\$15	\$15	\$15
Fitness Center	Covered	Covered in Full	Covered in Full
Dental	\$20 exam, two per year; \$20-\$30 X-rays	Not covered	\$20 exam, two per year; \$20-\$30 X-rays

*Includes \$0 Deductible Rx

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Preferred PPO

PCP selection, referrals for specialty care and network providers not required

	In-Network	Out-of-Network
Premium	\$2-\$118	
General Provisions		
Deductible	\$0	\$0
Coinsurance After Deductible	N/A	20%
OOP Maximum	\$1,500	\$3,000
Hospital Inpatient		
Non-Mental Health	\$0 per admission	20%
Mental Health	\$0 per admission	20%
SNF	\$45 per day (days 14-100)	20%
Home Health Care	\$0	20%
Hospital Outpatient		
Emergency Room	\$50	\$50
Ambulatory Surgical Center	\$75	20%
Outpatient Hospital Surgery	\$150	20%
Radiology - General (x-rays)	\$15	20%
Radiology - MRI/CAT/PET	\$75	20%
Pathology	\$0	20%
Physical/Occupational/Speech Therapy	\$20	20%
Preventive Screening Services	\$0	20%
Physician		
PCP Visits	\$10	\$20
Specialist Visits	\$20	\$30
Urgent Care	\$25	20%
Chiropractor	\$20	\$30
Podiatrist	\$20	\$30
Psych Serv (Ind/Grp)	\$25/\$10	20%
Sub. Abuse (Ind/Grp)	\$25/\$10	20%
Other		
Medicare Part B Covered Drugs	20%	20%
Ambulance	\$50	20%
DME / Supplies / Diabaetic Monitoring	20%	20%
Prosthetics	20%	20%
Immunizations	Covered in Full	20%
Vision Exams	\$20 (one per year)	\$30
Vision Hardware Reimbursement	\$200 every two years	20%
Hearing/Speech Exams	\$20 (one per year)	\$30
Hearing Aids Reimbursement	\$800 every three years	20%
Routine Physical Exams (1/yr)	\$10	\$20
Fitness Center	Covered in Full	20%
Dental	\$20 exam, two per year; \$20-\$30 X-rays	20%

Refer to Provider Service Center to verify benefits and cost sharing

Secure SNP

PCP selection, referrals for specialty care and network providers required

	Secure 1*	Secure 2
Premium	\$0	\$83
General Provisions		
Initial Coverage	N/A	N/A
Deductible	\$0	\$0
Coinsurance After Deductible	\$0	N/A
OOP Maximum	\$0	None
Hospital Inpatient		
Non-Mental Health	\$0	\$50 (1-5)
Mental Health	\$0	\$50 (1-5)
SNF	\$0	\$0 (1-100)
Home Health Care	\$0	\$10
Hospital Outpatient		
Emergency Room	\$0	\$50
Ambulatory Surgical Center	\$0	\$0
Outpatient Hospital Surgery	\$0	\$0
Radiology - General (x-rays)	\$0	\$0
Radiology - MRI/CAT/PET	\$0	\$0
Pathology	\$0	\$0
Physical/Occupational/Speech Therapy	\$0	\$0
Physician		
PCP Visits**	100% of fee schedule for PCPs	\$0
Specialist Visits	\$0	\$10
Urgent Care	\$0	\$50 (i)
Consults - OP (PCP/Spec)	\$0	\$0/\$10
Chiropractor	\$0	\$10
Podiatrist	\$0	\$10
Psych Serv (Ind/Grp)	\$0	\$25/\$10
Sub. Abuse (Ind/Grp)	\$0	\$25/\$10
Other		
Medicare Part B Covered Drugs	\$0	10%
Ambulance	\$0	\$50
DME / Supplies / Diabetic Monitoring	\$0	10%
Prosthetics	\$0	\$0
Preventive Services	\$0	\$0
Immunizations	Covered in Full	Covered
Vision Exams	\$0 (one per year)	\$10 1/yr
Vision Hardware Reimbursement	\$200 every two years	\$200/2 yrs
Hearing/Speech Exams	\$0 (one per year)	\$10 1/yr
Hearing Aids Reimbursement	\$1000 every three years	\$800/3 yrs
Routine Physical Exams (1/yr)	\$0	\$0
OTC Card	\$40 per calendar quarter	N/C
Dental	\$600 per year, visit every six months	\$600 per year, visit every six months; \$250 every five years denture coverage
Routine Transportation	Not covered	24 trips/yr

*Includes \$0 Deductible Rx

*Cost sharing listed for Secure 1 are member costs. Geisinger Gold will pay 80% of any claims. The remaining 20% must be billed to Medicaid

**PCP services reimbursed at 100% of applicable fee schedule rate
Refer to Provider Service Center to verify benefits and cost sharing

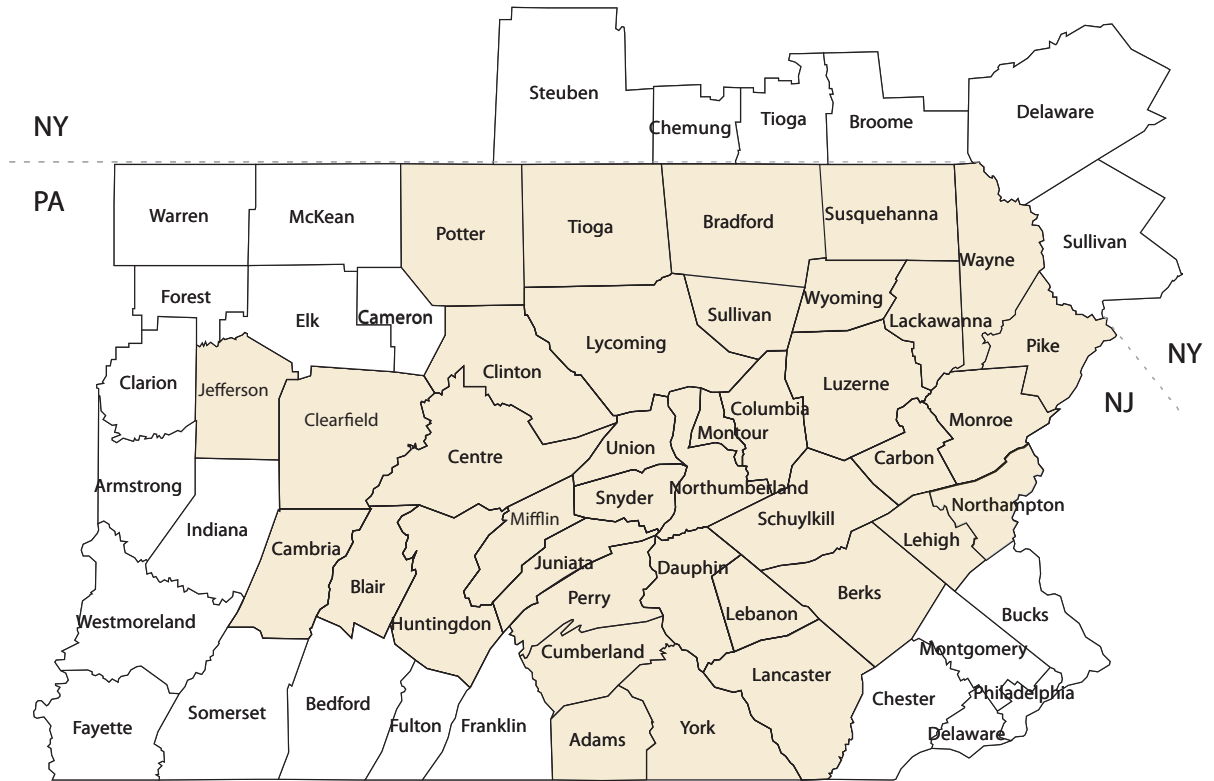
Reserve MSA

PCP selection, referrals for specialty care and network providers not required

Premium	\$0
General Provisions	
Initial Coverage	None
Deductible	Reserve 1 \$3,000; Reserve 2 \$4,000; Reserve 3 \$4,000; Reserve 4 \$5,000
Coinsurance After Deductible	None
OOP Maximum (a)	N/A
Fund Contribution	Reserve 1 \$1,500; Reserve 2 \$1,500; Reserve 3 \$1,260; Reserve 4 \$1,260
Hospital Inpatient	
Non-Mental Health	\$0 after deductible is met
Mental Health	\$0 after deductible is met
SNF	\$0 after deductible is met
Home Health Care	\$0 after deductible is met
Hospital Outpatient	
Emergency Room	\$0 after deductible is met
Ambulatory Surgical Center	\$0 after deductible is met
Outpatient Hospital Surgery	\$0 after deductible is met
Rad - General	\$0 after deductible is met
Rad - MRI/CAT/PET	\$0 after deductible is met
Pathology	\$0 after deductible is met
Physical/Occupational/Speech Therapy	\$0 after deductible is met
Physician	
PCP Visits	\$0 after deductible is met
Specialist Visits	\$0 after deductible is met
Urgent Care	\$0 after deductible is met
Physical Therapy	\$0 after deductible is met
Chiropractor	\$0 after deductible is met
Podiatrist	\$0 after deductible is met
Psych Serv (Ind/Grp)	\$0 after deductible is met
Sub. Abuse (Ind/Grp)	\$0 after deductible is met
Vision Exams	\$0 after deductible is met
Hearing/Speech Exams	\$0 after deductible is met
Other	
Medicare Cov Drugs	\$0 after deductible is met
Ambulance	\$0 after deductible is met
DME / Supplies / Diab Mon	\$0 after deductible is met
Prosthetics	\$0 after deductible is met
Preventive Services	\$0 after deductible is met

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Geisinger Gold Service Area



Medicare beneficiaries must live in the above service area to enroll in Classic or Preferred plans. Reserve and Open plans are available statewide. Secure plans are available in limited counties.



100 North Academy Avenue
Danville, PA 17822-3240

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