

Operations Bulletin 06-10



Date: November 15, 2010
To: Participating Providers
Subject: Geisinger Gold 2011

Geisinger Gold is pleased to introduce our 2011 Gold products.

Geisinger Gold 2011 continues to offer a variety of Medicare Advantage plans designed to meet the unique needs and budgets of Medicare beneficiaries throughout Pennsylvania.

Plans offered for 2011:

Classic 1 (HMO)	Preferred 1 (PPO)
Classic 2 (HMO)	Preferred 2 (PPO)*
Classic 3 (HMO)	Secure 1 (Dual Eligible SNP)
Classic PEBTF (HMO)	Secure 3 (Diabetic/CHF SNP)
Reserve (MSA)	

* New plan for 2011

Note: Secure 2, Open 3, and Gold Rx (a stand-alone prescription drug plan) plans have been closed for 2011

The Member cost-sharing grids in this Bulletin include more details on our 2011 plans. Additional information about Geisinger Gold, including tools to verify benefits and member eligibility can be found in the Provider Service Center at thehealthplan.com.

If you have any questions about Geisinger Gold, or would like additional reference materials for your office or patients, please contact the **Gold Customer Service Team at (800) 498-9731**, or your Provider Relations Representative:

Danville: (800) 876-5357
Harrisburg: (888) 281-5338
Scranton: (800) 350-6486
State College: (888) 669-4834

2011 Plan Highlights

- Out-of-pocket maximum on all plans
- \$0 cost-sharing for preventive services including, but not limited to:
 - Annual exam
 - AAA screening
 - Prostate cancer screening
 - Diabetic SCR/SM training
- Additional members through the Public School Employees' Retirement System (PSERS)
- Award winning health management programs

Geisinger Gold Member Identification Cards

	CLASSIC 1 (HMO) A Medicare Advantage Plan
	CMS: HXXXX-XXX
First Name Last Name ID #: 12345678901	
Medical Record #: 12345678	PCP Copay \$10
Primary Care: XXXX	Spec Copay \$20
XXXXXXXXXXXXXXXXXX	ER Copay \$50
Office #: 123/456-7891	
Tel-A-Nurse #: 877-543-5061	
www.GeisingerGold.com	

Geisinger Gold Customer Service: 1-800-498-9731 or 570-271-8771. TDD/TTY Hearing Impaired, contact PA Relay at: 711 Call if you have coverage questions and as soon as possible upon hospitalization or after an emergency. Emergencies: Call 911 or your local emergency service.	
To access Mental Health and Substance Abuse services, call 1-888-639-7972. Members with prescription benefit questions call 1-800-988-4861 or 570-271-5673.	
Mail Medical Claims to: Geisinger Health Plan P.O. Box 8200 Danville, PA 17821-8200	General Information: Geisinger Health Plan 100 N. Academy Avenue Danville, PA 17822-3229
XX-XX	Benefit Code: ABCDEFGHIJ Issue Date: Issuerdate
Pharmacists call 1-800-522-7487 for pharmacy benefit information.	
Mail Dental Claims to: Delta Dental, One Delta Drive, Mechanicsburg, PA 17055 For Dental benefit inquiries call 1-800-498-9731.	

Sample Gold Member Identification Cards are available online at thehealthplan.com. The front of the card will display the Member's PCP, SCP, and ER copays as well as 'No Referrals Required' if applicable.

Classic 1 (HMO) - *Must use a Participating Provider*

Covers routine office visits, physicals, immunizations, diagnostic tests and x-rays. Includes coverage towards eyeglasses, hearing aid and preventive dental benefits, Silver Sneakers/Forever Fit fitness center coverage, \$0 routine physicals, 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 \$2800 (premiums do not apply towards the annual maximum).

Classic 2 (HMO) - *Must use a Participating Provider*

Similar to Classic 1, with lower premium. Covers provider office visits and some routine services with a copay, including coverage towards eyeglasses, hearing aid and preventive dental benefits, Silver Sneakers/Forever Fit fitness center coverage, \$0 routine physicals, routine preventive services at \$0 copay, worldwide emergency room coverage and nationally accredited Health and Wellness programs. In addition, members pay 15% of most other services up to no more than \$3,400 per year (premiums do not apply towards the annual maximum).

Classic 3 (HMO) - *Must use a Participating Provider*

A zero-dollar plan premium (for Part C medical benefits) and \$0 routine physicals. Copays apply for services such as Primary Care and Specialist doctor visits, rehab, ER and partial hospitalization. Coverage includes eyeglasses, hearing aids and preventive dental benefits, plus worldwide emergency room coverage. For other covered services, plan pays the first \$500. Then the member pays the next \$2,200 in deductible. After that, services that apply to the deductible are covered in full.

Classic PEBTF (HMO) - *Must use a Participating Provider*

Available to eligible Commonwealth of Pennsylvania retirees. Zero cost-sharing for most inpatient and outpatient services. Small copays apply to Primary Care and Specialist doctor visits, rehab, and mental health services. In general, Member pays 100% for preventative dental services and routine hearing exams/hearing aids. Part D prescription drug coverage is facilitated through the Pennsylvania Employees Benefit Trust Fund REHP Prescription Drug plan.

Reserve (MSA)

A Medicare Advantage plan that links to a personal Medical Savings Account to help pay for medical expenses. As part of the enrollment process, the plan deposits \$1,500 directly into a personal Medical Savings Account. Reserve has a deductible of \$3,000, but no monthly premium. Members can go to any doctor or hospital that accepts Medicare and the plan's terms and conditions. No referrals are necessary. Once the deductible amount is met, the 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 stand-alone Medicare prescription drug plan at a separate cost.

All plans require members to continue to pay their monthly Medicare Part B premium and live in the service area.

Highlighted areas of Member cost-sharing grids below signify a change from Gold 2010.

Refer to Provider Service Center at www.thehealthplan.com to verify benefits and cost-sharing.

Preferred 1 (PPO)

No Primary Care Physician selection or referrals for specialists (in or out of network) are required with this plan. After a \$250 deductible (both in and out-of-network), this plan features a \$275 inpatient copay per hospital stay when in-network, fixed \$10/\$25 copays for PCP/Specialist visits in network and \$20/\$35 out-of-network (most other benefits covered at 20%). Includes coverage towards eyeglasses, hearing aid and preventive dental benefits, Forever Fit fitness center coverage, \$0 routine physicals, routine preventive services at \$0 copay, worldwide emergency room coverage, and nationally accredited Health and Wellness programs. Premiums do not apply towards the annual maximum.

Preferred 2 (PPO)

Similar to Preferred 1, with lower premium and higher cost sharing for member. Designed for members who would be interested in a Private Fee for Service type plan.

Secure 1 (HMO SNP – Dual Eligible)

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. Provider does not need to be participating in Medicaid to accept this product. However, the balance after our payment would not be the liability of the member. Members may not be balanced billed for any amount. Secure 1 also includes Part D prescription drug coverage, \$0 routine physicals, worldwide emergency services, dental benefits 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 \$50 per calendar quarter).

Secure 3 (HMO SNP – Diabetic/CHF)

Designed for people with diabetes and/or Chronic Heart Failure (CHF) who are eligible for Medicare Part A and enrolled in Part B. Secure 3 offers lower PCP office copays than Classic 1 to encourage members with diabetes and/or CHF to regularly see their PCP. Secure 3 also includes coverage for diabetic supplies at \$0 copay as well as enhanced \$0 deductible Part D prescription drug coverage, worldwide emergency services, \$0 routine physicals, and coverage towards eyeglasses, hearing aid and preventive dental benefits. Premiums do not apply towards the annual maximum.

Medicare Prescription Drug Coverage

All plans except Reserve (MSA) and Secure 1 (HMO SNP) are available with optional \$0 Deductible Rx prescription drug coverage. This benefit includes no initial deductible, initial coverage for 30 days, and \$6/\$39/\$69/33% cost sharing up to the coverage gap. Members will receive a discount on prescriptions while in the coverage gap.

All plans require members to continue to pay their monthly Medicare Part B premium and live in the service area.

Highlighted areas of Member cost-sharing grids below signify a change from Gold 2010.

Refer to Provider Service Center at www.thehealthplan.com to verify benefits and cost-sharing.

Classic HMO - 2011

PCP selection, referrals for specialty care, and network providers required

	Classic 1	Classic 2	Classic 3 (a)
General Provisions			
Deductible	\$0	\$0	\$2,200
OOP Maximum (b)	\$2,800	\$3,400	\$2,200
Hospital Inpatient			
Acute Care	\$100/day (days 1-5)	15%/\$2,000 Max	\$0 after deductible is met
Mental Health	\$100/day (days 1-5)	15%/\$2,000 Max	\$100/day (days 1-5)
SNF	\$75/day (days 7-100)	15%	\$0 after deductible is met
Home Health Care	\$0	\$0	\$0
Hospital Outpatient			
Emergency Room (worldwide)	\$50 (f)	\$50 (f)	\$50 (f)
Ambulatory Surgical Center	\$125	15%	\$0 after deductible is met
Outpatient Hospital Surgery	\$125	15%	\$0 after deductible is met
Radiology - General (X-rays)	\$25	\$25	\$0 after deductible is met
Radiology - MRI/CAT/PET	\$100	15%	\$0 after deductible is met
Therapeutic Radiology	\$45	15%	\$0 after deductible is met
Laboratory Tests	\$5	15%	\$0 after deductible is met
PT/OT/ST/CORF	\$10	\$10	\$25
Physician			
PCP Visits	\$10	\$10	\$10
Specialist Visits	\$20	\$20	\$25
Urgent Care	\$20	\$20	\$25
Physical Therapy	\$10	\$10	\$25
Chiropractor	\$20	\$20	\$25
Podiatrist	\$20	\$20	\$25
Psych Services (Ind/Grp)	\$25/\$10	\$25/\$10	\$25/\$10
Substance Abuse (Ind/Grp)	\$25/\$10	\$25/\$10	\$25/\$10
Other			
Medicare Part B Covered Drugs	10% (c)	15% (c)	\$0 after deductible is met
Ambulance (Waived if admitted)	\$100	\$100	\$0 after deductible is met
DME/Supplies/Diabetic Monitoring (d)	20%	20%	20%
Prosthetics	20%	20%	20%
Medicare Part B Covered Immunizations	\$0	\$0	\$0
Routine Vision Exams (1/year) (g)	\$20	\$20	\$25
Vision Hardware (reimbursement)	\$200 every 2 years	\$200 every 2 years	\$200 every 2 years
Routine Hearing Exams (1/year) (g)	\$20	\$20	\$25
Hearing Aids (reimbursement)	\$800 every 3 years	\$800 every 3 years	\$800 every 3 years
Routine Physical Exam (1/year)	\$0	\$0	\$0
Preventive Services	\$0	\$0	\$0
Routine Foot Care (4 times/year)	\$0	\$0	\$0
Fitness Center	\$0	\$0	\$0
Dental (e)	\$20 cleanings and exams, 2/year; \$20 - \$30 x-rays		
Part D	No Rx and \$0 deductible plans only		

- Notes:
- (a) \$500 initial coverage paid by the plan (Member pays nothing for first \$500 of covered services)
 - (b) Out-of-pocket maximum applies to coinsurance and copays
 - (c) \$1,000 OOP max on injectables and non-injectables. Coinsurance applies to both injectables and non-injectables
 - (d) 0% cost-sharing for Lifescan glucometers
 - (e) Does not apply to the plan level OOP Max
 - (f) \$50 copay waived if admitted to hospital within 3 days of visit
 - (g) No per year limit on diagnostic vision/hearing exams covered by Medicare

Classic PEBTF HMO - 2011

PCP selection, referrals for specialty care, and network providers required

	Classic HMO for Pennsylvania Employees Benefit Trust Fund
General Provisions	
Deductible	\$0
OOP Maximum (a)	\$2,500
Hospital Inpatient	
Acute Care	0% (no limit on number of days)
Mental Health	0% (no limit on number of days)
SNF	\$0/day (days 1-100)
Home Health Care	\$0
Hospital Outpatient	
Emergency Room (worldwide)	\$50 (b)
Ambulatory Surgical Center	\$0
Outpatient Hospital Surgery	\$0
Radiology - General (X-rays)	\$0
Radiology - MRI/CAT/PET	\$0
Therapeutic Radiology	\$0
Laboratory Tests	\$0
PT/OT/ST/CORF	\$10
Physician	
PCP Visits	\$10
Specialist Visits	\$15
Urgent Care	\$50 (b)
Physical Therapy	\$10
Chiropractor	\$15
Podiatrist	\$15
Psych Services (Ind/Grp)	\$15
Substance Abuse (Ind/Grp)	\$0
Other	
Medicare Part B Covered Drugs	\$0
Ambulance (Waived if admitted)	\$0
DME/Supplies/Diabetic Monitoring	\$0
Prosthetics	\$0
Medicare Part B Covered Immunizations	\$0
Vision Exams	\$0 Medicare-covered vision exams. Routine exams are not covered.
Vision Hardware (reimbursement)	Not Covered
Hearing Exams	\$0 Medicare-covered hearing exams. Routine exams are not covered.
Hearing Aids (reimbursement)	Not Covered
Routine Physical Exam (1/year)	\$0
Preventive Services	\$0
Routine Foot Care (4 times/year)	Not Covered
Fitness Center	\$0
Dental	Not Covered
Part D	Part D prescription drug coverage is facilitated through the Pennsylvania Employees Benefit Trust Fund REHP Prescription Drug plan

Notes: (a) Out-of-pocket maximum applies to coinsurance and copays
 (b) \$50 copay waived if admitted to hospital within 3 days of visit

Reserve MSA - 2011

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

	Reserve
General Provisions	
Deductible	\$3,000
Fund Contribution	\$1,500
OOP Maximum (a)	\$3,000
Hospital Inpatient	
Acute Care	\$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 (worldwide)	\$0 after deductible is met
Ambulatory Surgical Center	\$0 after deductible is met
Outpatient Hospital Surgery	\$0 after deductible is met
Radiology - General (X-rays)	\$0 after deductible is met
Radiology - MRI/CAT/PET	\$0 after deductible is met
Therapeutic Radiology	\$0 after deductible is met
Laboratory Tests	\$0 after deductible is met
PT/OT/ST/CORF	\$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 Services (Ind/Grp)	\$0 after deductible is met
Substance Abuse (Ind/Grp)	\$0 after deductible is met
Other	
Medicare Part B Covered Drugs	\$0 after deductible is met
Ambulance (Waived if admitted)	\$0 after deductible is met
DME/Supplies/Diabetic Monitoring (b)	\$0 after deductible is met
Prosthetics	\$0 after deductible is met
Medicare Part B Covered Immunizations	\$0 after deductible is met
Vision Exams	\$0 after deductible is met for Medicare-covered vision exams. Routine exams are not covered.
Vision Hardware (reimbursement)	Not Covered
Hearing Exams	\$0 after deductible is met for Medicare-covered hearing exams. Routine exams are not covered
Hearing Aids (reimbursement)	Not Covered
Annual Wellness Exam (1/year)	\$0 after deductible is met
Preventive Services	\$0 after deductible is met
Routine Foot Care (4 times/year)	Not Covered
Fitness Center	Not Covered
Dental (e)	Not Covered
Part D	N/A

Notes: (a) Out-of-pocket maximum applies to coinsurance and copays
(b) 0% cost-sharing for Lifescan glucometers

Medicare participation is required to treat and accept reimbursement for Reserve MSA Members. Reimbursement will equal Medicare's then-current rates for Medicare covered services.

Preferred PPO - 2011

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

	Preferred 1		Preferred 2 - NEW PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network
General Provisions				
Deductible	\$250	\$250	\$60	\$60
OOP Maximum (a)	\$2,550	\$5,100 (b)	\$3,000	\$5,100 (b)
Hospital Inpatient				
Acute Care	\$275/admission	20%	\$200/day (days 1-5)	25%
Mental Health	\$275/admission	20%	\$250/day (days 1-5)	25%
SNF	\$75/day (days 7-100)	20%	\$75/day (days 4-100)	25%
Home Health Care	\$0	20%	\$0	25%
Hospital Outpatient				
Emergency Room (worldwide)	\$50 (g)		\$50 (g)	
Ambulatory Surgical Center	\$125	20%	\$200	25%
Outpatient Hospital Surgery	\$125	20%	\$375	25%
Radiology - General (X-rays)	\$45	20%	\$45	25%
Radiology - MRI/CAT/PET	\$125	20%	20%	25%
Therapeutic Radiology	\$45	20%	20%	25%
Laboratory Tests	\$10	20%	20%	25%
PT/OT/ST/CORF	\$25	20%	\$35	25%
Physician				
PCP Visits	\$10	\$20	\$20	\$30
Specialist Visits	\$25	\$35	\$35	\$45
Urgent Care	\$25 (g)		\$35 (g)	
Physical Therapy	\$25	20%	\$35	25%
Chiropractor	\$25	\$35	\$35	\$45
Podiatrist	\$25	\$35	\$35	\$45
Psych Services (Ind/Grp)	\$25/\$10	20%	45%	45%
Substance Abuse (Ind/Grp)	\$25/\$10	20%	45%	45%
Other				
Medicare Part B Covered Drugs	20% (c)	20%	20% (c)	25%
Ambulance (Waived if admitted)	\$100	20%	\$100	25%
DME/Supplies/Diabetic Monitoring (d)	20%	20%	20%	25%
Prosthetics	20%	20%	20%	25%
Medicare Part B Covered Immunizations	\$0	20%	\$0	25%
Vision Exams (1/year) (h)	\$25	\$35	\$35	\$45
Vision Hardware (reimbursement)	\$200 every 2 years		\$200 every 2 years	
Hearing Exams (1/year) (h)	\$25	\$35	\$35	\$45
Hearing Aids (reimbursement)	\$800 every 3 years		\$800 every 3 years	
Routine Physical Exam (1/year)	\$0	\$20	\$0	\$30
Preventive Services	\$0	\$35 (e)	\$0	\$45 (e)
Routine Foot Care (4 times/year)	\$0	\$35	\$0	\$45
Fitness Center	\$0	20%	\$0	25%
Dental (f)	\$20 exams, 2/year; \$20 - \$30 X-rays	20%	\$20 exams, 2/year; \$20 - \$30 X-rays	25%
Part D	No Rx and \$0 deductible plans only		No Rx and \$0 deductible plans only	

- Notes:
- (a) Out-of-pocket maximum applies to coinsurance and copays
 - (b) Combined in- and out-of-network
 - (c) \$1,000 OOP max on injectables and non-injectables. Coinsurance applies to both injectables and non-injectables
 - (d) 0% cost-sharing for Lifescan glucometers
 - (e) Some preventive benefits under PPO plans feature the out-of-network coinsurance
 - (f) Does not apply to the plan level OOP Max
 - (g) \$50 copay waived if admitted to hospital within 3 days of visit
 - (h) No per year limit on diagnostic vision/hearing exams covered by Medicare

Secure SNP - 2011

PCP selection, referrals for specialty care, and network providers required

	Secure 1 (a)	Secure 3
General Provisions		
Deductible	\$0	\$0
OOP Maximum (b)	\$6,700	\$2,000
Hospital Inpatient		
Acute Care	\$0	\$100/day (days 1-5)
Mental Health	\$0	\$100/day (days 1-5)
SNF	\$0	\$60/day (days 7-100)
Home Health Care	\$0	\$0
Hospital Outpatient		
Emergency Room (worldwide)	\$0	\$50 (g)
Ambulatory Surgical Center	\$0	\$50
Outpatient Hospital Surgery	\$0	\$100
Radiology - General (X-rays)	\$0	\$15
Radiology - MRI/CAT/PET	\$0	\$75
Therapeutic Radiology	\$0	\$45
Laboratory Tests	\$0	\$5
PT/OT/ST/CORF	\$0	\$10
Physician		
PCP Visits	\$0	\$5
Specialist Visits	\$0	\$30
Urgent Care	\$0	\$30 (g)
Physical Therapy	\$0	\$10
Chiropractor	\$0	\$30
Podiatrist	\$0	\$30
Psych Services (Ind/Grp)	\$0	\$25/\$10
Substance Abuse (Ind/Grp)	\$0	\$25/\$10
Other		
Medicare Part B Covered Drugs	\$0	10% (c)
Ambulance (Waived if admitted)	\$0	\$100
DME	\$0	20%
Prosthetics	\$0	20%
Diabetic Supplies (d)	\$0	\$0
Medicare Part B Covered Immunizations	\$0	\$0
Vision Exams (1/year) (h)	\$0	\$20
Vision Hardware	\$200 every 2 years	\$200 every 2 years
Hearing Exams (1/year) (h)	\$0	\$20
Hearing Aids	\$1,000 every 3 years	\$800 every 3 years
Routine Physical Exam (1/year)	\$0	\$0
Preventive Services	\$0	\$0
Routine Foot Care (4 times/year)	\$0	\$0
Fitness Center	Not Covered	\$0
OTC Card	\$50/Q	Not Covered
Dental (e)	\$600 allowance (f)	\$20 exams, 2/year; \$20 - \$30 X-rays
Part D	Standard define benefit	\$0 deductible (coverage for some generics in gap)

Notes: (a) \$0 cost sharing assume full dual Medicare/Medicaid eligibilty

(b) Out-of-pocket maximum applies to coinsurance and copay

(c) \$1,000 OOP max on injectables and non-injectables. Coinsurance applies to both injectables and non-injectables

(d) 0% cost-sharing for Lifescan glucometers

(e) Does not apply to the plan level OOP Max

(f) Class I only, \$600 annual max. 1 visit per 6 months.

(g) \$50 copay waived if admitted to hospital within 3 days of visit

(h) No per year limit on diagnostic vision/hearing exams covered by Medicare

Medicaid participation not required to treat and accept reimbursement for Secure 1 Members. Providers may bill Medicaid as a secondary payer. However, Secure 1 Members may not be balanced billed for amounts reimbursed by Medicaid.

