Geisinger Gold Classic (HMO) Summary of Benefits

INTRODUCTION TO SUMMARY OF BENEFITS

Thank you for your interest in Geisinger Gold Classic (HMO). Our plan is offered by GEISINGER HEALTH PLAN/Geisinger Gold, a Medicare Advantage Health Maintenance Organization (HMO) that contracts with the Federal government. This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Geisinger Gold Classic (HMO) and ask for the "Evidence of Coverage".

YOU HAVE CHOICES IN YOUR HEALTH CARE

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like Geisinger Gold Classic (HMO). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call Geisinger Gold Classic (HMO) at the telephone number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

HOW CAN I COMPARE MY OPTIONS?

You can compare Geisinger Gold Classic (HMO) and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers. Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

WHERE IS GEISINGER GOLD CLASSIC (HMO) AVAILABLE?

There is more than one plan listed in this Summary of Benefits. Please refer to the chart in the back of this Summary for plan availability. If you move out of the state or county where you currently live, you must call Customer Service to update your information. If you don't, you may be disenrolled from Geisinger Gold. Please call Customer Service to find out if Geisinger Gold has a plan in your new state or county.

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WHO IS ELIGIBLE TO JOIN GEISINGER GOLD CLASSIC (HMO)?

You can join Geisinger Gold Classic (HMO) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End-Stage Renal Disease are generally not eligible to enroll in Geisinger Gold Classic (HMO) unless they are members of our organization and have been since their dialysis began.

CAN I CHOOSE MY DOCTORS?

Geisinger Gold Classic (HMO) has formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time.

You can ask for a current provider directory. For an updated list, visit us at https://www.thehealthplan.com/providersearch/selectsearch.cfm. Our customer service number is listed at the end of this introduction.

WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?

If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither the plan nor the Original Medicare Plan will pay for these services except in limited situations (for example, emergency care).

WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?

Geisinger Gold Classic (HMO) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at www.GeisingerGold.com. Our customer service number is listed at the end of this introduction.

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

Geisinger Gold Classic 1, Classic 3 and Classic 4 do cover Medicare Part B prescription drugs. Geisinger Gold Classic 1, Classic 3 and Classic 4 do NOT cover Medicare Part D prescription drugs. Geisinger Gold Classic 1 $0 Deductible Rx, Classic 3 $0 Deductible Rx and Classic 4 $0 Deductible Rx do cover both Part B and Part D drugs.

WHAT IS A PRESCRIPTION DRUG FORMULARY?
Geisinger Gold Classic (HMO) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected members before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at https://www.thehealthplan.com/Gold/Landing_Pages/Formulary/.
If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

HOW CAN I GET EXTRA HELP WITH MY PRESCRIPTION DRUG PLAN COSTS OR GET EXTRA HELP WITH OTHER MEDICARE COSTS?
You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:
- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week and see www.medicare.gov 'Programs for People with Limited Income and Resources' in the publication Medicare You.
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778 or
- Your State Medicaid Office.

WHAT ARE MY PROTECTIONS IN THIS PLAN?
All Medicare Advantage Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.
As a member of Geisinger Gold Classic (HMO), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.
As a member of Geisinger Gold Classic (HMO), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?
A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Geisinger Gold Classic (HMO) for more details.

WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?
Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Geisinger Gold Classic (HMO) for more details.
Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
Osteoporosis Drugs: Injectable osteoporosis drugs for some women.
Erythropoietin (Epoetin Alfa or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
Injectable Drugs: Most injectable drugs administered incident to a physician's service.
Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant took place in a Medicare-certified facility and was paid for by Medicare or by a private insurance company that was the primary payer for Medicare Part A coverage.
Some Oral Cancer Drugs: If the same drug is available in injectable form.
Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
Inhalation and Infusion Drugs administered through Durable Medical Equipment.

WHERE CAN I FIND INFORMATION ON PLAN RATINGS?
The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on www.medicare.gov and select "Health and Drug Plans" then "Compare Drug and Health Plans" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our customer service number is listed below.

Please call Geisinger Gold for more information about Geisinger Gold Classic (HMO).

Visit us at www.GeisingerGold.com or, call us:

Customer Service Hours for October 1 – February 14:

Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. - 8:00 p.m. Eastern

Customer Service Hours for February 15 – September 30:

For information related to the **Medicare Advantage Program, current members** should call:
- Toll Free: (800)-498-9731
- Locally: (570)-271-8771
- TTY/TDD 711

For information related to the **Medicare Part D Prescription Drug Program, current members** should call:
- Toll Free: (800)-988-4861
- Locally: (570)-271-8771
- TTY/TDD 711

For information related to the **Medicare Advantage Program or Medicare Part D Prescription Drug Program, prospective members** should call:
- Toll Free: (800)-514-0138
- TTY/TDD 711

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227).

TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Or, visit www.medicare.gov on the web.

This document may be available in other formats such as Braille, large print or other alternate formats.
This document may be available in a non-English language. For additional information, call customer service at the phone number listed above.

Summary of Benefits

If you have any questions about this plan's benefits or costs, please contact Geisinger Gold for details.

Benefit	Original Medicare	Classic 1 (HMO)	Classic 1 $0 Deductible Rx (HMO)	Classic 3 (HMO)	Classic 3 $0 Deductible (HMO)	Classic 4 (HMO)	Classic 4 $0 Deductible Rx (HMO)
IMPORTANT INFORMATION							
1 - Premium and Other Important Information	• In 2012 the monthly Part B Premium was $99.90 and may change for 2013 and the annual Part B deductible amount was $140 and may change for 2013. • If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more. • Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	*General* • Premiums range from $50 to $133 per month. Please refer to the Premium Table located after this section to find out what the premium is in your area. • You also must continue to pay your monthly Medicare Part B premium. • Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. *In-Network* • $2,800 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services. Contact plan for details regarding Non-	*General* • Premiums range from $88 to $171 per month. Please refer to the Premium Table located after this section to find out what the premium is in your area. • You also must continue to pay your monthly Medicare Part B premium. • Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. *In-Network* • $2,800 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services. Contact plan for details regarding Non-	*General* • $0 monthly plan premium in addition to your monthly Medicare Part B premium. • Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. *In-Network* • $1,300 annual deductible. Contact the plan for services that apply. • $2,000 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services. Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.	*General* • $41 monthly plan premium in addition to your monthly Medicare Part B premium. • Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. *In-Network* • $1,300 annual deductible. Contact the plan for services that apply. • $2,000 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services. Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.	*General* • $0 monthly plan premium in addition to your monthly Medicare Part B premium. • Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. *In-Network* • $1,600 annual deductible. Contact the plan for services that apply. • $2,300 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services. Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.	*General* • $45 monthly plan premium in addition to your monthly Medicare Part B premium. • Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. *In-Network* • $1,600 annual deductible. Contact the plan for services that apply. • $2,300 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services. Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.

Summary of Benefits

Benefit	Original Medicare	Classic 1 (HMO)	Classic 1 $0 Deductible Rx (HMO)	Classic 3 (HMO)	Classic 3 $0 Deductible (HMO)	Classic 4 (HMO)	Classic 4 $0 Deductible Rx (HMO)
		Medicare Supplemental Services covered under this limit.	Medicare Supplemental Services covered under this limit.				
2 - Doctor and Hospital Choice (For more information, see Emergency Care - #15 and Urgently Needed Care - #16.)	• You may go to any doctor, specialist or hospital that accepts Medicare.	***In-Network*** • You must go to network doctors, specialists, and hospitals. • Referral required for network specialists (for certain benefits).	***In-Network*** • You must go to network doctors, specialists, and hospitals. • Referral required for network specialists (for certain benefits).	***In-Network*** • You must go to network doctors, specialists, and hospitals. • Referral required for network specialists (for certain benefits).	***In-Network*** • You must go to network doctors, specialists, and hospitals. • Referral required for network specialists (for certain benefits).	***In-Network*** • You must go to network doctors, specialists, and hospitals. • Referral required for network specialists (for certain benefits).	***In-Network*** • You must go to network doctors, specialists, and hospitals. • Referral required for network specialists (for certain benefits).
INPATIENT CARE							
3 - Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	• In 2012 the amounts for each benefit period were: • Days 1 - 60: $1156 deductible • Days 61 - 90: $289 per day • Days 91 - 150: $578 per lifetime reserve day • These amounts may change for 2013. • Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. • Lifetime reserve days can only be used once. • A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each	***In-Network*** • No limit to the number of days covered by the plan each hospital stay. • For Medicare-covered hospital stays: • Days 1 - 5: $100 copay per day • Days 6 - 90: $0 copay per day • $0 copay for additional hospital days • Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	***In-Network*** • No limit to the number of days covered by the plan each hospital stay. • For Medicare-covered hospital stays: • Days 1 - 5: $100 copay per day • Days 6 - 90: $0 copay per day • $0 copay for additional hospital days • Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	***In-Network*** • No limit to the number of days covered by the plan each hospital stay. • $750 out-of-pocket limit every year. • $0 copay • Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	***In-Network*** • No limit to the number of days covered by the plan each hospital stay. • $750 out-of-pocket limit every year. • $0 copay • Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	***In-Network*** • No limit to the number of days covered by the plan each hospital stay. • $750 out-of-pocket limit every year. • $0 copay • Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	***In-Network*** • No limit to the number of days covered by the plan each hospital stay. • $750 out-of-pocket limit every year. • $0 copay • Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

Summary of Benefits

Benefit	Original Medicare	Classic 1 (HMO)	Classic 1 $0 Deductible Rx (HMO)	Classic 3 (HMO)	Classic 3 $0 Deductible (HMO)	Classic 4 (HMO)	Classic 4 $0 Deductible Rx (HMO)
	benefit period. There is no limit to the number of benefit periods you can have.						
4 - Inpatient Mental Health Care	• In 2012 the amounts for each benefit period were: • Days 1 - 60: $1156 deductible • Days 61 - 90: $289 per day • Days 91 - 150: $578 per lifetime reserve day • These amounts may change for 2013. • You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.	***In-Network*** • You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. • For Medicare-covered hospital stays: • Days 1 - 5: $100 copay per day • Days 6 - 90: $0 copay per day • Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	***In-Network*** • You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. • For Medicare-covered hospital stays: • Days 1 - 5: $100 copay per day • Days 6 - 90: $0 copay per day • Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	***In-Network*** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a ***General*** hospital. • For Medicare-covered hospital stays: • Days 1 - 5: $100 copay per day • Days 6 - 90: $0 copay per day • Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	***In-Network*** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a ***General*** hospital. • For Medicare-covered hospital stays: • Days 1 - 5: $100 copay per day • Days 6 - 90: $0 copay per day • Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	***In-Network*** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a ***General*** hospital. • For Medicare-covered hospital stays: • Days 1 - 5: $100 copay per day • Days 6 - 90: $0 copay per day • Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	***In-Network*** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a ***General*** hospital. • For Medicare-covered hospital stays: • Days 1 - 5: $100 copay per day • Days 6 - 90: $0 copay per day • Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
5 - Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	• In 2012 the amounts for each benefit period after at least a 3-day covered hospital stay were: • Days 1 - 20: $0 per day • Days 21 - 100: $144.50 per day • These amounts may change for 2013. • A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled	***General*** • Authorization rules may apply. ***In-Network*** • Plan covers up to 100 days each benefit period • No prior hospital stay is required. • For SNF stays: • Days 1 - 6: $0 copay per day • Days 7 - 44: $75 copay per day • Days 45 - 100: $0	***General*** • Authorization rules may apply. ***In-Network*** • Plan covers up to 100 days each benefit period • No prior hospital stay is required. • For SNF stays: • Days 1 - 6: $0 copay per day • Days 7 - 44: $75 copay per day • Days 45 - 100: $0	***General*** • Authorization rules may apply. ***In-Network*** • Plan covers up to 100 days each benefit period • No prior hospital stay is required. • $0 copay for SNF services • $1,000 out-of-pocket limit every year.	***General*** • Authorization rules may apply. ***In-Network*** • Plan covers up to 100 days each benefit period • No prior hospital stay is required. • $0 copay for SNF services • $1,000 out-of-pocket limit every year.	***General*** • Authorization rules may apply. ***In-Network*** • Plan covers up to 100 days each benefit period • No prior hospital stay is required. • $0 copay for SNF services • $1,000 out-of-pocket limit every year.	***General*** • Authorization rules may apply. ***In-Network*** • Plan covers up to 100 days each benefit period • No prior hospital stay is required. • $0 copay for SNF services • $1,000 out-of-pocket limit every year.

Summary of Benefits

Benefit	Original Medicare	Classic 1 (HMO)	Classic 1 $0 Deductible Rx (HMO)	Classic 3 (HMO)	Classic 3 $0 Deductible (HMO)	Classic 4 (HMO)	Classic 4 $0 Deductible Rx (HMO)
	nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	copay per day	copay per day				
6 - Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	• $0 copay.	***General*** • Authorization rules may apply. ***In-Network*** • $0 copay for Medicare-covered home health visits	***General*** • Authorization rules may apply. ***In-Network*** • $0 copay for Medicare-covered home health visits	***In-Network*** • $0 copay for Medicare-covered home health visits	***In-Network*** • $0 copay for Medicare-covered home health visits	***In-Network*** • $0 copay for Medicare-covered home health visits	***In-Network*** • $0 copay for Medicare-covered home health visits
7 - Hospice	• You pay part of the cost for outpatient drugs and inpatient respite care. • You must get care from a Medicare-certified hospice.	***General*** • You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.	***General*** • You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.	***General*** • You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.	***General*** • You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.	***General*** • You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.	***General*** • You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.
OUTPATIENT CARE 8 - Doctor Office Visits	• 20% coinsurance	***In-Network*** • $10 copay for each Medicare-covered primary care doctor visit. • $20 copay for each Medicare-covered specialist visit.	***In-Network*** • $10 copay for each Medicare-covered primary care doctor visit. • $20 copay for each Medicare-covered specialist visit.	***In-Network*** • $10 copay for each Medicare-covered primary care doctor visit. • $25 copay for each Medicare-covered specialist visit.	***In-Network*** • $10 copay for each Medicare-covered primary care doctor visit. • $25 copay for each Medicare-covered specialist visit.	***In-Network*** • $10 copay for each Medicare-covered primary care doctor visit. • $25 copay for each Medicare-covered specialist visit.	***In-Network*** • $10 copay for each Medicare-covered primary care doctor visit. • $25 copay for each Medicare-covered specialist visit.
9 - Chiropractic Services	• Supplemental routine care not covered • 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get	***In-Network*** • $20 copay for each Medicare-covered chiropractic visit • Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a	***In-Network*** • $20 copay for each Medicare-covered chiropractic visit • Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a	***In-Network*** • $20 copay for each Medicare-covered chiropractic visit • Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a	***In-Network*** • $20 copay for each Medicare-covered chiropractic visit • Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a	***In-Network*** • $20 copay for each Medicare-covered chiropractic visit • Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a	***In-Network*** • $20 copay for each Medicare-covered chiropractic visit • Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a

Summary of Benefits

Benefit	Original Medicare	Classic 1 (HMO)	Classic 1 $0 Deductible Rx (HMO)	Classic 3 (HMO)	Classic 3 $0 Deductible (HMO)	Classic 4 (HMO)	Classic 4 $0 Deductible Rx (HMO)
	it from a chiropractor or other qualified providers.	displacement or misalignment of a joint or body part) if you get it from a chiropractor.	displacement or misalignment of a joint or body part) if you get it from a chiropractor.	displacement or misalignment of a joint or body part) if you get it from a chiropractor.	displacement or misalignment of a joint or body part) if you get it from a chiropractor.	displacement or misalignment of a joint or body part) if you get it from a chiropractor.	displacement or misalignment of a joint or body part) if you get it from a chiropractor.
10 - Podiatry Services	• Supplemental routine care not covered. • 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	***In-Network*** • $20 copay for each Medicare-covered podiatry visit • $0 copay for up to 4 supplemental routine podiatry visit(s) every year • Medicare-covered podiatry visits are for medically-necessary foot care.	***In-Network*** • $20 copay for each Medicare-covered podiatry visit • $0 copay for up to 4 supplemental routine podiatry visit(s) every year • Medicare-covered podiatry visits are for medically-necessary foot care.	***In-Network*** • $25 copay for each Medicare-covered podiatry visit • $0 copay for up to 4 supplemental routine podiatry visit(s) every year • Medicare-covered podiatry visits are for medically-necessary foot care.	***In-Network*** • $25 copay for each Medicare-covered podiatry visit • $0 copay for up to 4 supplemental routine podiatry visit(s) every year • Medicare-covered podiatry visits are for medically-necessary foot care.	***In-Network*** • $25 copay for each Medicare-covered podiatry visit • $0 copay for up to 4 supplemental routine podiatry visit(s) every year • Medicare-covered podiatry visits are for medically-necessary foot care.	***In-Network*** • $25 copay for each Medicare-covered podiatry visit • $0 copay for up to 4 supplemental routine podiatry visit(s) every year • Medicare-covered podiatry visits are for medically-necessary foot care.
11 - Outpatient Mental Health Care	• 35% coinsurance for most outpatient mental health services • Specified copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Copay cannot exceed the Part A inpatient hospital deductible. • "Partial hospitalization program" is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	***General*** • Authorization rules may apply. ***In-Network*** • $25 copay for each Medicare-covered individual therapy visit • $10 copay for each Medicare-covered group therapy visit • $25 copay for each Medicare-covered individual therapy visit with a psychiatrist • $10 copay for each Medicare-covered group therapy visit with a psychiatrist • $25 copay for Medicare-covered partial hospitalization program services	***General*** • Authorization rules may apply. ***In-Network*** • $25 copay for each Medicare-covered individual therapy visit • $10 copay for each Medicare-covered group therapy visit • $25 copay for each Medicare-covered individual therapy visit with a psychiatrist • $10 copay for each Medicare-covered group therapy visit with a psychiatrist • $25 copay for Medicare-covered partial hospitalization program services	***General*** • Authorization rules may apply. ***In-Network*** • $25 copay for each Medicare-covered individual therapy visit • $10 copay for each Medicare-covered group therapy visit • $25 copay for each Medicare-covered individual therapy visit with a psychiatrist • $10 copay for each Medicare-covered group therapy visit with a psychiatrist • $0 copay for Medicare-covered partial hospitalization program services	***General*** • Authorization rules may apply. ***In-Network*** • $25 copay for each Medicare-covered individual therapy visit • $10 copay for each Medicare-covered group therapy visit • $25 copay for each Medicare-covered individual therapy visit with a psychiatrist • $10 copay for each Medicare-covered group therapy visit with a psychiatrist • $0 copay for Medicare-covered partial hospitalization program services	***General*** • Authorization rules may apply. ***In-Network*** • $25 copay for each Medicare-covered individual therapy visit • $10 copay for each Medicare-covered group therapy visit • $25 copay for each Medicare-covered individual therapy visit with a psychiatrist • $10 copay for each Medicare-covered group therapy visit with a psychiatrist • $0 copay for Medicare-covered partial hospitalization program services	***General*** • Authorization rules may apply. ***In-Network*** • $25 copay for each Medicare-covered individual therapy visit • $10 copay for each Medicare-covered group therapy visit • $25 copay for each Medicare-covered individual therapy visit with a psychiatrist • $10 copay for each Medicare-covered group therapy visit with a psychiatrist • $0 copay for Medicare-covered partial hospitalization program services

Summary of Benefits

Benefit	Original Medicare	Classic 1 (HMO)	Classic 1 $0 Deductible Rx (HMO)	Classic 3 (HMO)	Classic 3 $0 Deductible (HMO)	Classic 4 (HMO)	Classic 4 $0 Deductible Rx (HMO)
12 - Outpatient Substance Abuse Care	20% coinsurance	***General*** • Authorization rules may apply. ***In-Network*** • $25 copay for Medicare-covered individual substance abuse outpatient treatment visits • $10 copay for Medicare-covered group substance abuse outpatient treatment visits	***General*** • Authorization rules may apply. ***In-Network*** • $25 copay for Medicare-covered individual substance abuse outpatient treatment visits • $10 copay for Medicare-covered group substance abuse outpatient treatment visits	***General*** • Authorization rules may apply. ***In-Network*** • $25 copay for Medicare-covered individual substance abuse outpatient treatment visits • $10 copay for Medicare-covered group substance abuse outpatient treatment visits	***General*** • Authorization rules may apply. ***In-Network*** • $25 copay for Medicare-covered individual substance abuse outpatient treatment visits • $10 copay for Medicare-covered group substance abuse outpatient treatment visits	***General*** • Authorization rules may apply. ***In-Network*** • $25 copay for Medicare-covered individual substance abuse outpatient treatment visits • $10 copay for Medicare-covered group substance abuse outpatient treatment visits	***General*** • Authorization rules may apply. ***In-Network*** • $25 copay for Medicare-covered individual substance abuse outpatient treatment visits • $10 copay for Medicare-covered group substance abuse outpatient treatment visits
13 - Outpatient Services	• 20% coinsurance for the doctor's services • Specified copayment for outpatient hospital facility services Copay cannot exceed the Part A inpatient hospital deductible. • 20% coinsurance for ambulatory surgical center facility services	***General*** • Authorization rules may apply. ***In-Network*** • $250 copay for each Medicare-covered ambulatory surgical center visit • $125 to $250 copay for each Medicare-covered outpatient hospital facility visit	***General*** • Authorization rules may apply. ***In-Network*** • $250 copay for each Medicare-covered ambulatory surgical center visit • $125 to $250 copay for each Medicare-covered outpatient hospital facility visit	***General*** • Authorization rules may apply. ***In-Network*** • $0 copay for each Medicare-covered ambulatory surgical center visit • $0 copay for each Medicare-covered outpatient hospital facility visit	***General*** • Authorization rules may apply. ***In-Network*** • $0 copay for each Medicare-covered ambulatory surgical center visit • $0 copay for each Medicare-covered outpatient hospital facility visit	***General*** • Authorization rules may apply. ***In-Network*** • $0 copay for each Medicare-covered ambulatory surgical center visit • $0 copay for each Medicare-covered outpatient hospital facility visit	***General*** • Authorization rules may apply. ***In-Network*** • $0 copay for each Medicare-covered ambulatory surgical center visit • $0 copay for each Medicare-covered outpatient hospital facility visit
14 - Ambulance Services (medically necessary ambulance services)	• 20% coinsurance	***In-Network*** • $100 copay for Medicare-covered ambulance benefits. • If you are admitted to the hospital, you pay $0 for Medicare-covered ambulance benefits.	***In-Network*** • $100 copay for Medicare-covered ambulance benefits. • If you are admitted to the hospital, you pay $0 for Medicare-covered ambulance benefits.	***In-Network*** • $0 copay for Medicare-covered ambulance benefits.	***In-Network*** • $0 copay for Medicare-covered ambulance benefits.	***In-Network*** • $0 copay for Medicare-covered ambulance benefits.	***In-Network*** • $0 copay for Medicare-covered ambulance benefits.
15 - Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	• 20% coinsurance for the doctor's services • Specified copayment for outpatient hospital facility emergency services. • Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided	***General*** • $65 copay for Medicare-covered emergency room visits • Worldwide coverage. • If you are admitted to the hospital within 3-day(s) for the same condition, you	***General*** • $65 copay for Medicare-covered emergency room visits • Worldwide coverage. • If you are admitted to the hospital within 3-day(s) for the same condition, you	***General*** • $65 copay for Medicare-covered emergency room visits • Worldwide coverage. • If you are admitted to the hospital within 3-day(s) for the same condition, you	***General*** • $65 copay for Medicare-covered emergency room visits • Worldwide coverage. • If you are admitted to the hospital within 3-day(s) for the same condition, you	***General*** • $65 copay for Medicare-covered emergency room visits • Worldwide coverage. • If you are admitted to the hospital within 3-day(s) for the same condition, you	***General*** • $65 copay for Medicare-covered emergency room visits • Worldwide coverage. • If you are admitted to the hospital within 3-day(s) for the same condition, you

Summary of Benefits

Benefit	Original Medicare	Classic 1 (HMO)	Classic 1 $0 Deductible Rx (HMO)	Classic 3 (HMO)	Classic 3 $0 Deductible (HMO)	Classic 4 (HMO)	Classic 4 $0 Deductible Rx (HMO)
	by the hospital. • You don't have to pay the emergency room copay if you are admitted to the hospital as an inpatient for the same condition within 3 days of the emergency room visit. • Not covered outside the U.S. except under limited circumstances.	pay $0 for the emergency room visit.	pay $0 for the emergency room visit.	pay $0 for the emergency room visit.	pay $0 for the emergency room visit.	pay $0 for the emergency room visit.	pay $0 for the emergency room visit.
16 - Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	• 20% coinsurance, or a set copay • NOT covered outside the U.S. except under limited circumstances.	***General*** • $20 copay for Medicare-covered urgently-needed-care visits • If you are admitted to the hospital within 3-day(s) for the same condition, you pay $0 for the urgently-needed-care visit.	***General*** • $20 copay for Medicare-covered urgently-needed-care visits • If you are admitted to the hospital within 3-day(s) for the same condition, you pay $0 for the urgently-needed-care visit.	***General*** • $25 copay for Medicare-covered urgently-needed-care visits • If you are admitted to the hospital within 3-day(s) for the same condition, you pay $0 for the urgently-needed-care visit.	***General*** • $25 copay for Medicare-covered urgently-needed-care visits • If you are admitted to the hospital within 3-day(s) for the same condition, you pay $0 for the urgently-needed-care visit.	***General*** • $25 copay for Medicare-covered urgently-needed-care visits • If you are admitted to the hospital within 3-day(s) for the same condition, you pay $0 for the urgently-needed-care visit.	***General*** • $25 copay for Medicare-covered urgently-needed-care visits • If you are admitted to the hospital within 3-day(s) for the same condition, you pay $0 for the urgently-needed-care visit.
17 - Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	• 20% coinsurance	***General*** • Authorization rules may apply. ***In-Network*** • $10 copay for Medicare-covered Occupational Therapy visits • $10 copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits	***General*** • Authorization rules may apply. ***In-Network*** • $10 copay for Medicare-covered Occupational Therapy visits • $10 copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits	***General*** • Authorization rules may apply. ***In-Network*** • $25 copay for Medicare-covered Occupational Therapy visits • $25 copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits	***General*** • Authorization rules may apply. ***In-Network*** • $25 copay for Medicare-covered Occupational Therapy visits • $25 copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits	***General*** • Authorization rules may apply. ***In-Network*** • $25 copay for Medicare-covered Occupational Therapy visits • $25 copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits	***General*** • Authorization rules may apply. ***In-Network*** • $25 copay for Medicare-covered Occupational Therapy visits • $25 copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits

Summary of Benefits

Benefit	Original Medicare	Classic 1 (HMO)	Classic 1 $0 Deductible Rx (HMO)	Classic 3 (HMO)	Classic 3 $0 Deductible (HMO)	Classic 4 (HMO)	Classic 4 $0 Deductible Rx (HMO)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES							
18 - Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	• 20% coinsurance	***General*** • Authorization rules may apply. ***In-Network*** • 20% of the cost for Medicare-covered durable medical equipment	***General*** • Authorization rules may apply. ***In-Network*** • 20% of the cost for Medicare-covered durable medical equipment	***General*** • Authorization rules may apply. ***In-Network*** • 20% of the cost for Medicare-covered durable medical equipment	***General*** • Authorization rules may apply. ***In-Network*** • 20% of the cost for Medicare-covered durable medical equipment	***General*** • Authorization rules may apply. ***In-Network*** • 20% of the cost for Medicare-covered durable medical equipment	***General*** • Authorization rules may apply. ***In-Network*** • 20% of the cost for Medicare-covered durable medical equipment
19 - Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	• 20% coinsurance	***General*** • Authorization rules may apply. ***In-Network*** • 20% of the cost for Medicare-covered prosthetic devices	***General*** • Authorization rules may apply. ***In-Network*** • 20% of the cost for Medicare-covered prosthetic devices	***General*** • Authorization rules may apply. ***In-Network*** • 20% of the cost for Medicare-covered prosthetic devices	***General*** • Authorization rules may apply. ***In-Network*** • 20% of the cost for Medicare-covered prosthetic devices	***General*** • Authorization rules may apply. ***In-Network*** • 20% of the cost for Medicare-covered prosthetic devices	***General*** • Authorization rules may apply. ***In-Network*** • 20% of the cost for Medicare-covered prosthetic devices
20 - Diabetes Programs and Supplies	• 20% coinsurance for diabetes self-management training • 20% coinsurance for diabetes supplies • 20% coinsurance for diabetic therapeutic shoes or inserts	***General*** • Authorization rules may apply. ***In-Network*** • $0 copay for Medicare-covered Diabetes self-management training • 0% to 20% of the cost for Medicare-covered Diabetes monitoring supplies • 20% of the cost for Medicare-covered Therapeutic shoes or inserts	***General*** • Authorization rules may apply. ***In-Network*** • $0 copay for Medicare-covered Diabetes self-management training • 0% to 20% of the cost for Medicare-covered Diabetes monitoring supplies • 20% of the cost for Medicare-covered Therapeutic shoes or inserts	***General*** • Authorization rules may apply. ***In-Network*** • $0 copay for Medicare-covered Diabetes self-management training • 0% to 20% of the cost for Medicare-covered Diabetes monitoring supplies • 20% of the cost for Medicare-covered Therapeutic shoes or inserts	***General*** • Authorization rules may apply. ***In-Network*** • $0 copay for Medicare-covered Diabetes self-management training • 0% to 20% of the cost for Medicare-covered Diabetes monitoring supplies • 20% of the cost for Medicare-covered Therapeutic shoes or inserts	***General*** • Authorization rules may apply. ***In-Network*** • $0 copay for Medicare-covered Diabetes self-management training • 0% to 20% of the cost for Medicare-covered Diabetes monitoring supplies • 20% of the cost for Medicare-covered Therapeutic shoes or inserts	***General*** • Authorization rules may apply. ***In-Network*** • $0 copay for Medicare-covered Diabetes self-management training • 0% to 20% of the cost for Medicare-covered Diabetes monitoring supplies • 20% of the cost for Medicare-covered Therapeutic shoes or inserts
21 - Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	• 20% coinsurance for diagnostic tests and x-rays • $0 copay for Medicare-covered lab services • Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your	***General*** • Authorization rules may apply. ***In-Network*** • $5 copay for Medicare-covered lab services • $5 copay for Medicare-covered diagnostic proce-	***General*** • Authorization rules may apply. ***In-Network*** • $5 copay for Medicare-covered lab services • $5 copay for Medicare-covered diagnostic proce-	***In-Network*** • $0 copay for Medicare-covered: • lab services • diagnostic procedures and tests • X-rays • diagnostic radiology ser-	***In-Network*** • $0 copay for Medicare-covered: • lab services • diagnostic procedures and tests • X-rays • diagnostic radiology ser-	***In-Network*** • $0 copay for Medicare-covered: • lab services • diagnostic procedures and tests • X-rays • diagnostic radiology ser-	***In-Network*** • $0 copay for Medicare-covered: • lab services • diagnostic procedures and tests • X-rays • diagnostic radiology ser-

Summary of Benefits

Benefit	Original Medicare	Classic 1 (HMO)	Classic 1 $0 Deductible Rx (HMO)	Classic 3 (HMO)	Classic 3 $0 Deductible (HMO)	Classic 4 (HMO)	Classic 4 $0 Deductible Rx (HMO)
	treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most supplemental routine screening tests, like checking your cholesterol.	dures and tests • $25 copay for Medicare-covered X-rays • $25 to $100 copay for Medicare-covered diagnostic radiology services (not including X-rays) • $25 to $45 copay for Medicare-covered therapeutic radiology services	dures and tests • $25 copay for Medicare-covered X-rays • $25 to $100 copay for Medicare-covered diagnostic radiology services (not including X-rays) • $25 to $45 copay for Medicare-covered therapeutic radiology services	vices (not including X-rays) • therapeutic radiology services	vices (not including X-rays) • therapeutic radiology services	vices (not including X-rays) • therapeutic radiology services	vices (not including X-rays) • therapeutic radiology services
22 - Cardiac and Pulmonary Rehabilitation Services	• 20% coinsurance for Cardiac Rehabilitation services • 20% coinsurance for Pulmonary Rehabilitation services • 20% coinsurance for Intensive Cardiac Rehabilitation services • This applies to program services provided in a doctor's office. Specified cost sharing for program services provided by hospital outpatient departments.	***General*** • Authorization rules may apply. ***In-Network*** • $10 copay for Medicare-covered Cardiac Rehabilitation Services • $10 copay for Medicare-covered Intensive Cardiac Rehabilitation Services • $10 copay for Medicare-covered Pulmonary Rehabilitation Services	***General*** • Authorization rules may apply. ***In-Network*** • $10 copay for Medicare-covered Cardiac Rehabilitation Services • $10 copay for Medicare-covered Intensive Cardiac Rehabilitation Services • $10 copay for Medicare-covered Pulmonary Rehabilitation Services	***In-Network*** • $10 copay for Medicare-covered Cardiac Rehabilitation Services • $10 copay for Medicare-covered Intensive Cardiac Rehabilitation Services • $10 copay for Medicare-covered Pulmonary Rehabilitation Services	***In-Network*** • $10 copay for Medicare-covered Cardiac Rehabilitation Services • $10 copay for Medicare-covered Intensive Cardiac Rehabilitation Services • $10 copay for Medicare-covered Pulmonary Rehabilitation Services	***In-Network*** • $10 copay for Medicare-covered Cardiac Rehabilitation Services • $10 copay for Medicare-covered Intensive Cardiac Rehabilitation Services • $10 copay for Medicare-covered Pulmonary Rehabilitation Services	***In-Network*** • $10 copay for Medicare-covered Cardiac Rehabilitation Services • $10 copay for Medicare-covered Intensive Cardiac Rehabilitation Services • $10 copay for Medicare-covered Pulmonary Rehabilitation Services

Summary of Benefits

Benefit	Original Medicare	Classic 1 (HMO)	Classic 1 $0 Deductible Rx (HMO)	Classic 3 (HMO)	Classic 3 $0 Deductible (HMO)	Classic 4 (HMO)	Classic 4 $0 Deductible Rx (HMO)
PREVENTIVE SERVICES, WELLNESS/ EDUCATION AND OTHER SUPPLEMENTAL BEN- EFIT PROGRAMS							
23 -Preventive Services, Wellness/Education and other Supplemental Ben- efit Programs	• No coinsurance, copay- ment or deductible for the following: • - Abdominal Aortic An- eurysm Screening • - Bone Mass Measure- ment. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions. • - Cardiovascular Screen- ing • Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk. • Colorectal Cancer Screen- ing • Diabetes Screening • Influenza Vaccine • Hepatitis B Vaccine for people with Medicare who are at risk • HIV Screening. $0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit. HIV screening is covered for people with Medicare who are pregnant	*General* • $0 copay for all preven- tive services covered under Original Medicare at zero cost sharing. • Any additional preven- tive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. ***In-Network*** • $10 copay for an annual physical exam • The plan covers the fol- lowing supplemental edu- cation/wellness programs: • Health Club Member- ship/Fitness Classes • Nursing Hotline • $0 copay for Enhanced Preventive Health Services. • Contact plan for details.	*General* • $0 copay for all preven- tive services covered under Original Medicare at zero cost sharing. • Any additional preven- tive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. ***In-Network*** • $10 copay for an annual physical exam • The plan covers the fol- lowing supplemental edu- cation/wellness programs: • Health Club Member- ship/Fitness Classes • Nursing Hotline • $0 copay for Enhanced Preventive Health Services. • Contact plan for details.	*General* • $0 copay for all preven- tive services covered under Original Medicare at zero cost sharing. • Any additional preven- tive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. ***In-Network*** • $10 copay for an annual physical exam • The plan covers the fol- lowing supplemental edu- cation/wellness programs: • Health Education • Health Club Member- ship/Fitness Classes • Nursing Hotline • $0 copay for Enhanced Preventive Health Services. • Contact plan for details.	*General* • $0 copay for all preven- tive services covered under Original Medicare at zero cost sharing. • Any additional preven- tive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. ***In-Network*** • $10 copay for an annual physical exam • The plan covers the fol- lowing supplemental edu- cation/wellness programs: • Health Education • Health Club Member- ship/Fitness Classes • Nursing Hotline • $0 copay for Enhanced Preventive Health Services. • Contact plan for details.	*General* • $0 copay for all preven- tive services covered under Original Medicare at zero cost sharing. • Any additional preven- tive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. ***In-Network*** • $10 copay for an annual physical exam • The plan covers the fol- lowing supplemental edu- cation/wellness programs: • Health Education • Health Club Member- ship/Fitness Classes • Nursing Hotline • $0 copay for Enhanced Preventive Health Services. • Contact plan for details.	*General* • $0 copay for all preven- tive services covered under Original Medicare at zero cost sharing. • Any additional preven- tive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. ***In-Network*** • $10 copay for an annual physical exam • The plan covers the fol- lowing supplemental edu- cation/wellness programs: • Health Education • Health Club Member- ship/Fitness Classes • Nursing Hotline • $0 copay for Enhanced Preventive Health Services. • Contact plan for details.

Summary of Benefits

Benefit	Original Medicare	Classic 1 (HMO)	Classic 1 $0 Deductible Rx (HMO)	Classic 3 (HMO)	Classic 3 $0 Deductible (HMO)	Classic 4 (HMO)	Classic 4 $0 Deductible Rx (HMO)
	and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. • Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39. • Medical Nutrition Therapy Services Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease • Personalized Prevention Plan • Services (Annual Wellness Visits) • Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information. • Prostate Cancer Screening						

Summary of Benefits

Benefit	Original Medicare	Classic 1 (HMO)	Classic 1 $0 Deductible Rx (HMO)	Classic 3 (HMO)	Classic 3 $0 Deductible (HMO)	Classic 4 (HMO)	Classic 4 $0 Deductible Rx (HMO)
	• Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50. • Smoking and Tobacco Use Cessation (counseling to stop smoking and tobacco use). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. • Screening and behavioral counseling interventions in primary care to reduce alcohol misuse • Screening for depression in adults • Screening for sexually transmitted infections (STI) and high-intensity behavioral counseling to prevent STIs • Intensive behavioral counseling for Cardiovascular Disease (bi-annual) • Intensive behavioral therapy for obesity • Welcome to Medicare Preventive Visits (initial preventive physical exam) When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Preventive Visits or an Annual Wellness Visit. After your first 12						

Summary of Benefits

Benefit	Original Medicare	Classic 1 (HMO)	Classic 1 $0 Deductible Rx (HMO)	Classic 3 (HMO)	Classic 3 $0 Deductible (HMO)	Classic 4 (HMO)	Classic 4 $0 Deductible Rx (HMO)
	months, you can get one • Annual Wellness Visit every 12 months.						
24 - Kidney Disease and Conditions	• 20% coinsurance for renal dialysis • 20% coinsurance for kidney disease education services	*In-Network* • 20% of the cost for Medicare-covered renal dialysis • $0 copay for Medicare-covered kidney disease education services	*In-Network* • 20% of the cost for Medicare-covered renal dialysis • $0 copay for Medicare-covered kidney disease education services	*In-Network* • 20% of the cost for Medicare-covered renal dialysis • $0 copay for Medicare-covered kidney disease education services	*In-Network* • 20% of the cost for Medicare-covered renal dialysis • $0 copay for Medicare-covered kidney disease education services	*In-Network* • 20% of the cost for Medicare-covered renal dialysis • $0 copay for Medicare-covered kidney disease education services	*In-Network* • 20% of the cost for Medicare-covered renal dialysis • $0 copay for Medicare-covered kidney disease education services
PRESCRIPTION DRUG BENEFITS **25 - Outpatient Prescription Drugs**	• Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	***Drugs covered under Medicare Part B*** ***General*** • Most drugs not covered. • 10% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs. ***Drugs covered under Medicare Part D*** ***General*** • This plan does not offer prescription drug coverage.	***Drugs covered under Medicare Part B*** ***General*** • 10% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs. ***Drugs covered under Medicare Part D*** ***General*** • This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at https://www.thehealthplan.com/Gold/Landing_Pages/Formulary/ on the web. • Different out-of-pocket costs may apply for people who • have limited incomes, • live in long term care facilities, or • have access to Indian/Tribal/Urban (Indian Health Service) providers.	***Drugs covered under Medicare Part B*** ***General*** • Most drugs not covered. • 10% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs. ***Drugs covered under Medicare Part D*** ***General*** • This plan does not offer prescription drug coverage.	***Drugs covered under Medicare Part B*** ***General*** • 10% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs. ***Drugs covered under Medicare Part D*** ***General*** • This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at https://www.thehealthplan.com/Gold/Landing_Pages/Formulary/ on the web. • Different out-of-pocket costs may apply for people who • have limited incomes, • live in long term care facilities, or • have access to Indian/Tribal/Urban (Indian Health Service) providers.	***Drugs covered under Medicare Part B*** ***General*** • Most drugs not covered. • 10% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs. ***Drugs covered under Medicare Part D*** ***General*** • This plan does not offer prescription drug coverage.	***Drugs covered under Medicare Part B*** ***General*** • 10% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs. ***Drugs covered under Medicare Part D*** ***General*** • This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at https://www.thehealthplan.com/Gold/Landing_Pages/Formulary/ on the web. • Different out-of-pocket costs may apply for people who • have limited incomes, • live in long term care facilities, or • have access to Indian/Tribal/Urban (Indian Health Service) providers.

Summary of Benefits

Benefit	Original Medicare	Classic 1 (HMO)	Classic 1 $0 Deductible Rx (HMO)	Classic 3 (HMO)	Classic 3 $0 Deductible (HMO)	Classic 4 (HMO)	Classic 4 $0 Deductible Rx (HMO)
			• The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). • Total yearly drug costs are the total drug costs paid by both you and a Part D plan. • The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. • Some drugs have quantity limits. • Your provider must get prior authorization from Geisinger Gold Classic 1 $0 Deductible Rx (HMO) for certain drugs. • You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan		• The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). • Total yearly drug costs are the total drug costs paid by both you and a Part D plan. • The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. • Some drugs have quantity limits. • Your provider must get prior authorization from Geisinger Gold Classic 3 $0 Deductible Rx (HMO) for certain drugs. • You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan		• The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). • Total yearly drug costs are the total drug costs paid by both you and a Part D plan. • The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. • Some drugs have quantity limits. • Your provider must get prior authorization from Geisinger Gold Classic 4 $0 Deductible Rx (HMO) for certain drugs. • You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan

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			Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. • If you request a formulary exception for a drug and Geisinger Gold Classic 1 $0 Deductible Rx (HMO) approves the exception, you will pay Tier 4: Non-Preferred Brand cost sharing for that drug. ***In-Network*** • $0 deductible. ***Initial Coverage*** • You pay the following until total yearly drug costs reach $2,970: ***Retail Pharmacy*** • Tier 1: Preferred Generic • - $3 copay for a one-month (34-day) supply of drugs in this tier • $9 copay for a three-month (90-day) supply of drugs in this tier • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. • Tier 2: Non-Preferred Generic • $7 copay for a one-month (34-day) supply of drugs in this tier • $21 copay for a three-month (90-day) supply of drugs in this tier		Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. • If you request a formulary exception for a drug and Geisinger Gold Classic 3 $0 Deductible Rx (HMO) approves the exception, you will pay Tier 4: Non-Preferred Brand cost sharing for that drug. ***In-Network*** • $0 deductible. ***Initial Coverage*** • You pay the following until total yearly drug costs reach $2,970: ***Retail Pharmacy*** • Tier 1: Preferred Generic • - $3 copay for a one-month (34-day) supply of drugs in this tier • $9 copay for a three-month (90-day) supply of drugs in this tier • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. • Tier 2: Non-Preferred Generic • $7 copay for a one-month (34-day) supply of drugs in this tier • $21 copay for a three-month (90-day) supply of drugs in this tier		Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. • If you request a formulary exception for a drug and Geisinger Gold Classic 4$0 Deductible Rx (HMO) approves the exception, you will pay Tier 4: Non-Preferred Brand cost sharing for that drug. ***In-Network*** • $0 deductible. ***Initial Coverage*** • You pay the following until total yearly drug costs reach $2,970: ***Retail Pharmacy*** • Tier 1: Preferred Generic • - $3 copay for a one-month (34-day) supply of drugs in this tier • $9 copay for a three-month (90-day) supply of drugs in this tier • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. • Tier 2: Non-Preferred Generic • $7 copay for a one-month (34-day) supply of drugs in this tier • $21 copay for a three-month (90-day) supply of drugs in this tier

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Benefit	Original Medicare	Classic 1 (HMO)	Classic 1 $0 Deductible Rx (HMO)	Classic 3 (HMO)	Classic 3 $0 Deductible (HMO)	Classic 4 (HMO)	Classic 4 $0 Deductible Rx (HMO)

			• Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.
			• Tier 3: Preferred Brand
			  • $39 copay for a one-month (34-day) supply of drugs in this tier
			  • $117 copay for a three-month (90-day) supply of drugs in this tier
			• Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.
			• Tier 4: Non-Preferred Brand
			  • $69 copay for a one-month (34-day) supply of drugs in this tier
			  • $207 copay for a three-month (90-day) supply of drugs in this tier
			• Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.
			• Tier 5: Specialty Tier
			  • 33% coinsurance for a one-month (34-day) supply of drugs in this tier
			Long Term Care Pharmacy
			• Tier 1: Preferred Generic
			  • $3 copay for a one-month (34-day) supply of drugs in this tier
			• Tier 2: Non-Preferred Generic
					• Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.
					• Tier 3: Preferred Brand
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							• Tier 1: Preferred Generic
							  • $3 copay for a one-month (34-day) supply of drugs in this tier
							• Tier 2: Non-Preferred Generic

Benefit	Original Medicare	Classic 1 (HMO)	Classic 1 $0 Deductible Rx (HMO)	Classic 3 (HMO)	Classic 3 $0 Deductible (HMO)	Classic 4 (HMO)	Classic 4 $0 Deductible Rx (HMO)
			• $7 copay for a one-month (34-day) supply of drugs in this tier • Tier 3: Preferred Brand • $39 copay for a one-month (34-day) supply of drugs in this tier • Tier 4: Non-Preferred Brand • $69 copay for a one-month (34-day) supply of drugs in this tier • Tier 5: Specialty Tier • 33% coinsurance for a one-month (34-day) supply of drugs in this tier • Please note that brand drugs must be dispensed incrementally in long-term care facilities. Generic drugs may be dispensed incrementally. Contact your plan about cost-sharing billing/collection when less than a one-month supply is dispensed. ***Mail Order*** • Tier 1: Preferred Generic • $9 copay for a three-month (90-day) supply of drugs in this tier • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Tier 2: Non-Preferred Generic • $21 copay for a three-month (90-day) supply of drugs in this tier		• $7 copay for a one-month (34-day) supply of drugs in this tier • Tier 3: Preferred Brand • $39 copay for a one-month (34-day) supply of drugs in this tier • Tier 4: Non-Preferred Brand • $69 copay for a one-month (34-day) supply of drugs in this tier • Tier 5: Specialty Tier • 33% coinsurance for a one-month (34-day) supply of drugs in this tier • Please note that brand drugs must be dispensed incrementally in long-term care facilities. Generic drugs may be dispensed incrementally. Contact your plan about cost-sharing billing/collection when less than a one-month supply is dispensed. ***Mail Order*** • Tier 1: Preferred Generic • $9 copay for a three-month (90-day) supply of drugs in this tier • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Tier 2: Non-Preferred Generic • $21 copay for a three-month (90-day) supply of drugs in this tier		• $7 copay for a one-month (34-day) supply of drugs in this tier • Tier 3: Preferred Brand • $39 copay for a one-month (34-day) supply of drugs in this tier • Tier 4: Non-Preferred Brand • $69 copay for a one-month (34-day) supply of drugs in this tier • Tier 5: Specialty Tier • 33% coinsurance for a one-month (34-day) supply of drugs in this tier • Please note that brand drugs must be dispensed incrementally in long-term care facilities. Generic drugs may be dispensed incrementally. Contact your plan about cost-sharing billing/collection when less than a one-month supply is dispensed. ***Mail Order*** • Tier 1: Preferred Generic • $9 copay for a three-month (90-day) supply of drugs in this tier • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Tier 2: Non-Preferred Generic • $21 copay for a three-month (90-day) supply of drugs in this tier

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			Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Tier 3: Preferred Brand • $117 copay for a three-month (90-day) supply of drugs in this tier • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. • Tier 4: Non-Preferred Brand • $207 copay for a three-month (90-day) supply of drugs in this tier • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. ***Coverage Gap*** • After your total yearly drug costs reach $2,970, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 47.5% for the plan's costs for brand drugs and 79% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach $4,750. ***Additional Coverage Gap*** • The plan covers few formulary generics (less than 10% of formulary generic		Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Tier 3: Preferred Brand • $117 copay for a three-month (90-day) supply of drugs in this tier • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. • Tier 4: Non-Preferred Brand • $207 copay for a three-month (90-day) supply of drugs in this tier • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. ***Coverage Gap*** • After your total yearly drug costs reach $2,970, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 47.5% for the plan's costs for brand drugs and 79% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach $4,750. ***Additional Coverage Gap*** • The plan covers few formulary generics (less than 10% of formulary generic		Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Tier 3: Preferred Brand • $117 copay for a three-month (90-day) supply of drugs in this tier • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. • Tier 4: Non-Preferred Brand • $207 copay for a three-month (90-day) supply of drugs in this tier • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. ***Coverage Gap*** • After your total yearly drug costs reach $2,970, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 47.5% for the plan's costs for brand drugs and 79% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach $4,750. ***Additional Coverage Gap*** • The plan covers few formulary generics (less than 10% of formulary generic

Benefit	Original Medicare	Classic 1 (HMO)	Classic 1 $0 Deductible Rx (HMO)	Classic 3 (HMO)	Classic 3 $0 Deductible (HMO)	Classic 4 (HMO)	Classic 4 $0 Deductible Rx (HMO)
			drugs) through the coverage gap. • The plan offers additional coverage in the gap for the following tiers. • You pay the following: ***Retail Pharmacy*** • Tier 1: Preferred Generic • $3 copay for a one-month (34-day) supply of all drugs covered in this tier • $9 copay for a three-month (90-day) supply of all drugs covered in this tier • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. ***Long Term Care Pharmacy*** • Tier 1: Preferred Generic • $3 copay for a one-month (34-day) supply of all drugs covered in this tier • Mail Order • Tier 1: Preferred Generic • $9 copay for a three-month (90-day) supply of all drugs covered in this tier • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. ***Catastrophic Coverage*** • After your yearly out-of-pocket drug costs reach $4,750, you pay the greater		drugs) through the coverage gap. • The plan offers additional coverage in the gap for the following tiers. • You pay the following: ***Retail Pharmacy*** • Tier 1: Preferred Generic • $3 copay for a one-month (34-day) supply of all drugs covered in this tier • $9 copay for a three-month (90-day) supply of all drugs covered in this tier • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. ***Long Term Care Pharmacy*** • Tier 1: Preferred Generic • $3 copay for a one-month (34-day) supply of all drugs covered in this tier • Mail Order • Tier 1: Preferred Generic • $9 copay for a three-month (90-day) supply of all drugs covered in this tier • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. ***Catastrophic Coverage*** • After your yearly out-of-pocket drug costs reach $4,750, you pay the greater		drugs) through the coverage gap. • The plan offers additional coverage in the gap for the following tiers. • You pay the following: ***Retail Pharmacy*** • Tier 1: Preferred Generic • $3 copay for a one-month (34-day) supply of all drugs covered in this tier • $9 copay for a three-month (90-day) supply of all drugs covered in this tier • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. ***Long Term Care Pharmacy*** • Tier 1: Preferred Generic • $3 copay for a one-month (34-day) supply of all drugs covered in this tier • Mail Order • Tier 1: Preferred Generic • $9 copay for a three-month (90-day) supply of all drugs covered in this tier • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. ***Catastrophic Coverage*** • After your yearly out-of-pocket drug costs reach $4,750, you pay the greater

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			of: • -5% coinsurance, or • $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copay for all other drugs. ***Out-of-Network*** • Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Geisinger Gold Classic 1 $0 Deductible Rx (HMO). ***Out-of-Network Initial Coverage*** • You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,970: • Tier 1: Preferred Generic • $3 copay for a one-month (34-day) supply of drugs in this tier • Tier 2: Non-Preferred Generic • $7 copay for a one-		of: • -5% coinsurance, or • $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copay for all other drugs. ***Out-of-Network*** • Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Geisinger Gold Classic 3 $0 Deductible Rx (HMO). ***Out-of-Network Initial Coverage*** • You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,970: • Tier 1: Preferred Generic • $3 copay for a one-month (34-day) supply of drugs in this tier • Tier 2: Non-Preferred Generic • $7 copay for a one-		of: • -5% coinsurance, or • $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copay for all other drugs. ***Out-of-Network*** • Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Geisinger Gold Classic 4$0 Deductible Rx (HMO). ***Out-of-Network Initial Coverage*** • You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,970: • Tier 1: Preferred Generic • $3 copay for a one-month (34-day) supply of drugs in this tier • Tier 2: Non-Preferred Generic • $7 copay for a one-

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			month (34-day) supply of drugs in this tier • Tier 3: Preferred Brand • $39 copay for a one-month (34-day) supply of drugs in this tier • Tier 4: Non-Preferred Brand • $69 copay for a one-month (34-day) supply of drugs in this tier • Tier 5: Specialty Tier • 33% coinsurance for a one-month (34-day) supply of drugs in this tier ***Out-of-Network Coverage Gap*** • You will be reimbursed up to 21% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,750. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). • You will be reimbursed up to 52.5% of the plan allowable cost for brand name drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach $4,750. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). ***Additional Out-of-Network***		month (34-day) supply of drugs in this tier • Tier 3: Preferred Brand • $39 copay for a one-month (34-day) supply of drugs in this tier • Tier 4: Non-Preferred Brand • $69 copay for a one-month (34-day) supply of drugs in this tier • Tier 5: Specialty Tier • 33% coinsurance for a one-month (34-day) supply of drugs in this tier ***Out-of-Network Coverage Gap*** • You will be reimbursed up to 21% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,750. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). • You will be reimbursed up to 52.5% of the plan allowable cost for brand name drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach $4,750. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). ***Additional Out-of-Network***		month (34-day) supply of drugs in this tier • Tier 3: Preferred Brand • $39 copay for a one-month (34-day) supply of drugs in this tier • Tier 4: Non-Preferred Brand • $69 copay for a one-month (34-day) supply of drugs in this tier • Tier 5: Specialty Tier • 33% coinsurance for a one-month (34-day) supply of drugs in this tier ***Out-of-Network Coverage Gap*** • You will be reimbursed up to 21% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,750. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). • You will be reimbursed up to 52.5% of the plan allowable cost for brand name drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach $4,750. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). ***Additional Out-of-Network***

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Benefit	Original Medicare	Classic 1 (HMO)	Classic 1 $0 Deductible Rx (HMO)	Classic 3 (HMO)	Classic 3 $0 Deductible (HMO)	Classic 4 (HMO)	Classic 4 $0 Deductible Rx (HMO)
			Coverage Gap • The plan covers few formulary generics (less than 10% of formulary generic drugs) through the coverage gap. • You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following: Tier 1: Preferred Generic • $3 copay for a one-month (34-day) supply of all drugs covered in this tier ***Out-of-Network Catastrophic Coverage*** • After your yearly out-of-pocket drug costs reach $4,750, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: • 5% coinsurance, or • $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copay for all other drugs.		***Coverage Gap*** • The plan covers few formulary generics (less than 10% of formulary generic drugs) through the coverage gap. • You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following: Tier 1: Preferred Generic • $3 copay for a one-month (34-day) supply of all drugs covered in this tier ***Out-of-Network Catastrophic Coverage*** • After your yearly out-of-pocket drug costs reach $4,750, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: • 5% coinsurance, or • $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copay for all other drugs.		***Coverage Gap*** • The plan covers few formulary generics (less than 10% of formulary generic drugs) through the coverage gap. • You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following: Tier 1: Preferred Generic • $3 copay for a one-month (34-day) supply of all drugs covered in this tier ***Out-of-Network Catastrophic Coverage*** • After your yearly out-of-pocket drug costs reach $4,750, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: • 5% coinsurance, or • $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copay for all other drugs.

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OUTPATIENT MEDICAL SERVICES AND SUPPLIES							
26 - Dental Services	• Preventive dental services (such as cleaning) not covered.	*General* • Authorization rules may apply. *In-Network* • $0 copay for Medicare-covered dental benefits • $20 copay for a visit that includes: • up to 1 oral exam(s) every six months • up to 1 cleaning(s) every six months • $20 to $30 copay for up to 1 dental x-ray(s) every year	*General* • Authorization rules may apply. *In-Network* • $0 copay for Medicare-covered dental benefits • $20 copay for a visit that includes: • up to 1 oral exam(s) every six months • up to 1 cleaning(s) every six months • $20 to $30 copay for up to 1 dental x-ray(s) every year	*In-Network* • $0 copay for Medicare-covered dental benefits • $20 copay for a visit that includes: • up to 1 oral exam(s) every six months • up to 1 cleaning(s) every six months • $20 to $30 copay for up to 1 dental x-ray(s) every year	*In-Network* • $0 copay for Medicare-covered dental benefits • $20 copay for a visit that includes: • up to 1 oral exam(s) every six months • up to 1 cleaning(s) every six months • $20 to $30 copay for up to 1 dental x-ray(s) every year	*In-Network* • $0 copay for Medicare-covered dental benefits • $20 copay for a visit that includes: • up to 1 oral exam(s) every six months • up to 1 cleaning(s) every six months • $20 to $30 copay for up to 1 dental x-ray(s) every year	*In-Network* • $0 copay for Medicare-covered dental benefits • $20 copay for a visit that includes: • up to 1 oral exam(s) every six months • up to 1 cleaning(s) every six months • $20 to $30 copay for up to 1 dental x-ray(s) every year
27 - Hearing Services	• Supplemental routine hearing exams and hearing aids not covered. • 20% coinsurance for diagnostic hearing exams.	*In-Network* • $0 copay for : • up to 1 fitting-evaluation(s) for a hearing aid every three years • $0 copay for up to 1 hearing aid(s) every three years • $20 copay for Medicare-covered diagnostic hearing exams • $20 copay for up to 1 supplemental routine hearing exam(s) every year • $800 plan coverage limit for hearing aids every three years.	*In-Network* • $0 copay for : • up to 1 fitting-evaluation(s) for a hearing aid every three years • $0 copay for up to 1 hearing aid(s) every three years • $20 copay for Medicare-covered diagnostic hearing exams • $20 copay for up to 1 supplemental routine hearing exam(s) every year • $800 plan coverage limit for hearing aids every three years.	*In-Network* • $0 copay for up to 1 hearing aid(s) every three years • $25 copay for Medicare-covered diagnostic hearing exams • $25 copay for up to 1 supplemental routine hearing exam(s) every year • $0 copay for up to 1 hearing aid fitting-evaluation(s) every three years • $800 plan coverage limit for hearing aids every three years.	*In-Network* • $0 copay for up to 1 hearing aid(s) every three years • $25 copay for Medicare-covered diagnostic hearing exams • $25 copay for up to 1 supplemental routine hearing exam(s) every year • $0 copay for up to 1 hearing aid fitting-evaluation(s) every three years • $800 plan coverage limit for hearing aids every three years.	*In-Network* • $0 copay for up to 1 hearing aid(s) every three years • $25 copay for Medicare-covered diagnostic hearing exams • $25 copay for up to 1 supplemental routine hearing exam(s) every year • $0 copay for up to 1 hearing aid fitting-evaluation(s) every three years • $800 plan coverage limit for hearing aids every three years.	*In-Network* • $0 copay for up to 1 hearing aid(s) every three years • $25 copay for Medicare-covered diagnostic hearing exams • $25 copay for up to 1 supplemental routine hearing exam(s) every year • $0 copay for up to 1 hearing aid fitting-evaluation(s) every three years • $800 plan coverage limit for hearing aids every three years.

Summary of Benefits

Benefit	Original Medicare	Classic 1 (HMO)	Classic 1 $0 Deductible Rx (HMO)	Classic 3 (HMO)	Classic 3 $0 Deductible (HMO)	Classic 4 (HMO)	Classic 4 $0 Deductible Rx (HMO)
28 - Vision Services	• 20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. • Supplemental routine eye exams and glasses not covered. • Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. • Annual glaucoma screenings covered for people at risk.	*In-Network* • $0 copay for • one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery • $0 to $20 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. • $0 copay for • glasses • contacts • lenses • frames • $20 copay for up to 1 supplemental routine eye exam(s) every year • $200 plan coverage limit for eye wear every two years.	*In-Network* • $0 copay for • one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery • $0 to $20 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. • $0 copay for • glasses • contacts • lenses • frames • $20 copay for up to 1 supplemental routine eye exam(s) every year • $200 plan coverage limit for eye wear every two years.	*In-Network* • $0 copay for • one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery • up to 1 pair(s) of glasses every two years • up to 1 pair(s) of contacts every two years • up to 1 pair(s) of lenses every two years • up to 1 frame(s) every two years • $0 to $25 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. • $25 copay for up to 1 supplemental routine eye exam(s) every year • $200 plan coverage limit for eye wear every two years.	*In-Network* • $0 copay for • one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery • up to 1 pair(s) of glasses every two years • up to 1 pair(s) of contacts every two years • up to 1 pair(s) of lenses every two years • up to 1 frame(s) every two years • $0 to $25 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. • $25 copay for up to 1 supplemental routine eye exam(s) every year • $200 plan coverage limit for eye wear every two years.	*In-Network* • $0 copay for • one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery • up to 1 pair(s) of glasses every two years • up to 1 pair(s) of contacts every two years • up to 1 pair(s) of lenses every two years • up to 1 frame(s) every two years • $0 to $25 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. • $25 copay for up to 1 supplemental routine eye exam(s) every year • $200 plan coverage limit for eye wear every two years.	*In-Network* • $0 copay for • one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery • up to 1 pair(s) of glasses every two years • up to 1 pair(s) of contacts every two years • up to 1 pair(s) of lenses every two years • up to 1 frame(s) every two years • $0 to $25 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. • $25 copay for up to 1 supplemental routine eye exam(s) every year • $200 plan coverage limit for eye wear every two years.
Over-the-Counter Items	• Not covered.	*General* • The plan does not cover Over-the-Counter items.	*General* • The plan does not cover Over-the-Counter items.	*General* • The plan does not cover Over-the-Counter items.	*General* • The plan does not cover Over-the-Counter items.	*General* • The plan does not cover Over-the-Counter items.	*General* • The plan does not cover Over-the-Counter items.
Transportation (Routine)	• Not covered.	*In-Network* • This plan does not cover supplemental routine transportation.	*In-Network* • This plan does not cover supplemental routine transportation.	*In-Network* • This plan does not cover supplemental routine transportation.	*In-Network* • This plan does not cover supplemental routine transportation.	*In-Network* • This plan does not cover supplemental routine transportation.	*In-Network* • This plan does not cover supplemental routine transportation.
Acupuncture	• Not covered.	*In-Network* • This plan does not cover Acupuncture.	*In-Network* • This plan does not cover Acupuncture.	*In-Network* • This plan does not cover Acupuncture.	*In-Network* • This plan does not cover Acupuncture.	*In-Network* • This plan does not cover Acupuncture.	*In-Network* • This plan does not cover Acupuncture.

2013 Monthly Premiums by County of Residence

Please locate your county in the list below for plan availability and monthly premium.

	Classic 1 (HMO)	Classic 1 $0 Deductible Rx (HMO)	Classic 3 (HMO)	Classic 3 $0 Deductible Rx (HMO)	Classic 4 (HMO)	Classic 4 $0 Deductible Rx (HMO)
Adams	$112	$142	$0	$41	NA	NA
Berks	$133	$171	$0	$41	NA	NA
Blair	$133	$171	$0	$41	NA	NA
Cambria	$133	$171	$0	$41	NA	NA
Cameron	$112	$142	$0	$41	NA	NA
Carbon	$50	$88	NA	NA	$0	$45
Centre	$112	$142	$0	$41	NA	NA
Clearfield	$112	$142	$0	$41	NA	NA
Clinton	$133	$171	$0	$41	NA	NA
Columbia	$133	$171	$0	$41	NA	NA
Cumberland	$112	$142	$0	$41	NA	NA
Dauphin	$112	$142	$0	$41	NA	NA
Fulton	$133	$171	$0	$41	NA	NA
Huntingdon	$133	$171	$0	$41	NA	NA
Jefferson	$112	$142	$0	$41	NA	NA
Juniata	$133	$171	$0	$41	NA	NA
Lackawanna	$118	$158	$0	$41	NA	NA
Lancaster	$112	$142	$0	$41	NA	NA
Lebanon	$112	$142	$0	$41	NA	NA
Lehigh	$50	$88	NA	NA	$0	$45
Luzerne	$118	$158	$0	$41	NA	NA
Lycoming	$133	$171	$0	$41	NA	NA
Mifflin	$112	$142	$0	$41	NA	NA
Monroe	$133	$171	$0	$41	NA	NA
Montour	$133	$171	$0	$41	NA	NA
Northampton	$50	$88	NA	NA	$0	$45
Northumberland	$133	$171	$0	$41	NA	NA
Perry	$112	$142	$0	$41	NA	NA
Pike	$133	$171	$0	$41	NA	NA
Potter	$133	$171	$0	$41	NA	NA
Schuylkill	$133	$171	$0	$41	NA	NA
Snyder	$133	$171	$0	$41	NA	NA
Somerset	$133	$171	$0	$41	NA	NA
Sullivan	$112	$142	$0	$41	NA	NA
Susquehanna	$112	$142	$0	$41	NA	NA
Tioga	$133	$171	$0	$41	NA	NA
Union	$133	$171	$0	$41	NA	NA
Wayne	$133	$171	$0	$41	NA	NA
Wyoming	$133	$171	$0	$41	NA	NA
York	$112	$142	$0	$41	NA	NA