



2012 SUMMARY OF BENEFITS



**Introduction to the Summary of Benefits Report
For Gateway Health Plan *Medicare Assured*[®] (HMO SNP)
January 1, 2012 – December 31, 2012
Pennsylvania**

Thank you for your interest in Gateway Health Plan *Medicare Assured*[®] (HMO SNP). Our plan is offered by Gateway Health Plan[®], Inc./ Gateway Health Plan *Medicare Assured*[®], a Medicare Advantage Health Maintenance Organization (HMO) Special Needs Plan (SNP).

This plan is designed for people who meet specific enrollment criteria. You may be eligible to join this plan if you receive assistance from the state and Medicare.

All cost sharing in this Summary of Benefits is based on your level of Medicaid eligibility.

Please call Gateway Health Plan *Medicare Assured*[®] (HMO SNP) to find out if you are eligible to join. Our number is listed at the end of this introduction.

This Summary of Benefits tells you some of the features of our plan. It doesn't list every service we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Gateway Health Plan *Medicare Assured*[®] (HMO SNP) 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 Gateway Health Plan *Medicare Assured*[®] (HMO SNP). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

If you are eligible for both Medicare and Medicaid (dual eligible) you may join or leave a plan at any time.

Please call Gateway Health Plan *Medicare Assured*[®] (HMO SNP) at the 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 Gateway Health Plan *Medicare Assured*[®] (HMO SNP) 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 GATEWAY HEALTH PLAN *MEDICARE ASSURED*[®] (HMO SNP) AVAILABLE?

The service area for this plan includes: Adams, Allegheny, Armstrong, Beaver, Berks, Blair, Butler, Cambria, Cumberland, Dauphin, Erie, Fayette, Indiana, Lackawanna, Lancaster, Lawrence, Lebanon, Lehigh, Mercer, Northampton, Northumberland, Perry, Philadelphia, Schuylkill, Somerset, Washington, Westmoreland, and York Counties, PA. You must live in one of these areas to join the Plan.

WHO IS ELIGIBLE TO JOIN GATEWAY HEALTH PLAN *MEDICARE ASSURED*[®] (HMO SNP)?

You can join Gateway Health Plan *Medicare Assured*[®] (HMO SNP) 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 generally are not eligible to enroll in Gateway Health Plan *Medicare Assured*[®] (HMO SNP) unless they are members of our organization and have been since their dialysis began.

You must also be enrolled in the Pennsylvania Medical Assistance program to join this plan.

Please call the plan to see if you are eligible to join.

CAN I CHOOSE MY DOCTORS?

Gateway Health Plan *Medicare Assured*[®] (HMO SNP) has formed a network of doctors, specialists, and hospitals. You can only use doctors who are a 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 www.GatewayHealthPlan.com/Medicare. Our customer service number is listed at the end of this introduction.

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

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

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

Gateway Health Plan *Medicare Assured*[®] (HMO SNP) 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.GatewayHealthPlan.com/Medicare. Our customer service number is listed at the end of this introduction.

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

Gateway Health Plan *Medicare Assured*[®] (HMO SNP) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

Gateway Health Plan *Medicare Assured*[®] (HMO SNP) 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 enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our web site at www.GatewayHealthPlan.com/Medicare.

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.

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HOW CAN I GET EXTRA HELP WITH 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 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 Gateway Health Plan *Medicare Assured*[®] (HMO SNP), 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 Gateway Health Plan *Medicare Assured*[®] (HMO SNP), 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

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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 Gateway Health Plan *Medicare Assured*[®] (HMO SNP) 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 Gateway Health Plan *Medicare Assured*[®] (HMO SNP) 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 drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin Alpha 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 was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- 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 provided through DME.

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 Gateway Health Plan *Medicare Assured*[®] (HMO SNP) for more information about Gateway Health Plan *Medicare Assured*[®] (HMO SNP).

Visit us at **www.GatewayHealthPlan.com/Medicare**, or call us:

Member Service Hours:
Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday
8 a.m. – 8 p.m. Eastern

Current members should call (toll-free):

1-800-685-5209 for questions related to the Medicare Advantage Program and the Medicare Part D Prescription Drug program.
(TTY 711)

Prospective members should call (toll-free):

1-877-GATEWAY (1-877-428-3929) for questions related to the Medicare Advantage Program and the Medicare Part D Prescription Drug program. **(TTY 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 Member Services at the number listed above.

Esta información puede estar disponible en otros formatos, como en idioma inglés y letras grandes. Si necesita información del plan en otro formato o idioma, comuníquese con Servicios para Miembros al número que se indica anteriormente.

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<p>If you have any questions about this plan’s benefits or costs, please contact Gateway Health Plan Medicare Assured® (HMO SNP) for details.</p>		
<p>Benefit Category</p>	<p>Original Medicare</p>	<p>Gateway Health Plan Medicare Assured® (HMO SNP)</p>
<p>1. Premium and Other Important Information</p>	<p>In 2012, the monthly Part B Premium is \$0 and the yearly Part B deductible is \$0.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p>	<p><u>General</u></p> <p>* Depending on your level of Medicaid eligibility, you may not have any cost-sharing responsibility for original Medicare services.</p> <p>** Please consult with your plan about cost sharing when receiving services from out-of-network providers</p> <p>\$0 monthly plan premium.*</p> <p><u>In-Network</u></p> <p>\$0 yearly deductible.*</p> <p>\$3,400 out-of-pocket limit for Medicare-covered services. However, in this plan you will have no cost sharing responsibility for Medicare-covered services, based on your level of Medicaid responsibility.</p>
<p>2. Doctor and Hospital Choice</p> <p>(For more information, see Emergency Care - #15 and Urgently Needed Care - #16)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p><u>In-Network</u></p> <p>You must go to network doctors, specialists, and hospitals.</p> <p>No referral required for network doctors, specialists, and hospitals.</p>

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Benefit Category	Original Medicare	Gateway Health Plan Medicare Assured® (HMO SNP)
INPATIENT CARE		
<p>3. Inpatient Hospital Care</p> <p>(includes Substance Abuse and Rehabilitation Services)</p>	<p>For each benefit period: Days 1 - 60: \$0 deductible Days 61- 90: \$0 per day Days 91 - 150: \$0 per lifetime reserve day</p> <p>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.</p> <p>Lifetime reserve days can only be used once.</p> <p>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. There is no limit to the number of benefit periods you can have.</p>	<p><u>In-Network</u> No limit to the number of days covered by the plan each benefit period.</p> <p>\$0 annual deductible.*</p> <p>\$0 co-payment.*</p> <p>\$175 co-payment for each additional hospital day.*</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
<p>4. Inpatient Mental Health Care</p>	<p>For each benefit period: Days 1 - 60: \$0 deductible Days 61- 90: \$0 per day Days 91 - 150: \$0 per lifetime reserve day</p> <p>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.</p>	<p><u>In-Network</u> \$0 co-payment.*</p> <p>Contact the Plan for details about coverage in Psychiatric Hospital beyond 190 days.</p> <p>\$0 annual deductible.*</p> <p>Plan covers 60 lifetime reserve days. \$0 co-payment per lifetime reserve day.*</p> <p>For additional hospital days: Days 91-190: \$0 co-payment per day.*</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>

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<p>5. Skilled Nursing Facility (SNF) (In a Medicare-certified skilled nursing facility)</p>	<p>In 2012, the amounts for each benefit period after at least a 3-day covered hospital stay are: Days 1-20: \$0 per day Days 21 – 100: \$0 per day</p> <p>100 days for each benefit period.</p> <p>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 nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you may have.</p>	<p><u>General</u> Authorization rules may apply.</p> <p><u>In-Network</u> Plan covers up to 100 days each benefit period.</p> <p>No prior hospital stay is required.</p> <p>\$0 annual deductible.* \$0 co-payment for SNF services.*</p> <p>You will not be charged additional cost sharing for professional services.</p> <p>For non-Medicare-covered SNF stays: Days 1-20: \$0 per day* Days 21-100: \$0 per day*</p> <p>See page 22 for additional information.</p>
<p>6. Home Health Care (Includes medically necessary intermittent skilled nursing care, home health aide services and rehabilitation services, etc.)</p>	<p>\$0 co-payment.</p>	<p><u>General</u> Authorization rules may apply.</p> <p><u>In-Network</u> \$0 co-payment for Medicare-covered home health visits.*</p>
<p>7. Hospice</p>	<p>You must get care from a Medicare-certified hospice.</p>	<p><u>General</u> You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.</p>
<p>OUTPATIENT CARE</p>		
<p>8. Doctor Office Visits</p>	<p>0% coinsurance.</p>	<p><u>In-Network</u> \$0 co-payment for each primary care doctor visit for Medicare-covered benefits.*</p> <p>\$0 co-payment for the cost of each in-area, network urgent care Medicare-covered visit.*</p> <p>\$0 co-payment for each specialist doctor visit for Medicare-covered benefits.*</p>

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<p>Benefit Category</p>	<p>Original Medicare</p>	<p>Gateway Health Plan Medicare Assured® (HMO SNP)</p>
<p>9. Chiropractic Services</p>	<p>Supplemental routine care not covered.</p> <p>0% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified provider.</p>	<p><u>General</u> Authorization rules may apply.</p> <p><u>In-Network</u> \$0 co-payment for Medicare-covered chiropractic visits.*</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p>
<p>10. Podiatry Services</p>	<p>Supplemental routine care not covered.</p> <p>0% coinsurance for medically necessary foot care, including care for medical conditions affecting the low limbs.</p>	<p><u>In-Network</u> \$0 co-payment for Medicare-covered podiatry benefits.*</p> <p>20% of the cost for each supplemental routine visit.*</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p>
<p>11. Outpatient Mental Health Care</p>	<p>0% coinsurance for most outpatient mental health services.</p> <p>0% coinsurance of the Medicare-approved amount for each service you get from a qualified professional as part of a Partial Hospitalization Program.</p> <p>“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.”</p>	<p><u>General</u> Authorization rules may apply.</p> <p><u>In-Network</u> \$0 co-payment for Medicare-covered Mental Health visits.*</p> <p>\$0 co-payment for each Medicare-covered visit with a psychiatrist.*</p> <p>\$0 co-payment for Medicare-covered partial hospitalization program services.*</p>

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<p>Benefit Category</p>	<p>Original Medicare</p>	<p>Gateway Health Plan Medicare Assured® (HMO SNP)</p>
<p>12. Outpatient Substance Abuse Care</p>	<p>0% coinsurance.</p>	<p><u>General</u> Authorization rules may apply.</p> <p><u>In-Network</u> \$0 co-payment for Medicare-covered visits.*</p>
<p>13. Outpatient Services/Surgery</p>	<p>0% coinsurance for the doctor’s services.</p> <p>0% coinsurance for ambulatory surgical center facility services.</p>	<p><u>In-Network</u> \$0 co-payment for each Medicare-covered ambulatory surgical center visit.*</p> <p>\$0 co-payment for each Medicare-covered outpatient hospital facility visit.*</p>
<p>14. Ambulance Services</p> <p>(Medically necessary ambulance services)</p>	<p>0% coinsurance.</p>	<p><u>General</u> Authorization rules may apply.</p> <p><u>In-Network</u> \$0 co-payment for Medicare-covered ambulance benefits.*</p>
<p>15. Emergency Care</p> <p>(You may go to any emergency room if you reasonably believe you need emergency care.)</p>	<p>0% coinsurance for the doctor’s services.</p> <p>0% outpatient hospital facility emergency services.</p> <p>Not covered outside the U.S. except under limited circumstances.</p>	<p><u>General</u> \$0 co-payment for Medicare-covered emergency room visits.*</p> <p>Not covered outside the U.S. except under limited circumstances. Contact the Plan for more details.</p>
<p>16. Urgently Needed Care</p> <p>(This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>0% coinsurance.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p><u>General</u> \$0 co-payment for Medicare-covered urgently-needed-care visits.*</p>

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<p align="center">If you have any questions about this plan’s benefits or costs, please contact Gateway Health Plan Medicare Assured® (HMO SNP) for details.</p>		
Benefit Category	Original Medicare	Gateway Health Plan Medicare Assured® (HMO SNP)
<p>17. Outpatient Rehabilitation Services</p> <p>(Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p>	0% coinsurance.	<p><u>General</u> Authorization rules may apply.</p> <p><u>In-Network</u> \$0 co-payment for Medicare-covered Occupational Therapy visits.*</p> <p>\$0 co-payment for Medicare-covered Physical and/or Speech and Language Therapy visits.*</p>
<p align="center">OUTPATIENT MEDICAL SERVICES AND SUPPLIES</p>		
<p>18. Durable Medical Equipment</p> <p>(Includes wheelchairs, oxygen, etc.)</p>	0% coinsurance.	<p><u>General</u> Authorization rules may apply.</p> <p><u>In-Network</u> \$0 co-payment for Medicare-covered items.*</p>
<p>19. Prosthetic Devices</p> <p>(Includes braces, artificial limbs and eyes, etc.)</p>	0% coinsurance.	<p><u>General</u> Authorization rules may apply.</p> <p><u>In-Network</u> \$0 co-payment for Medicare-covered items.*</p>
<p>20. Diabetes Programs and Supplies</p>	<p>0% coinsurance for diabetes self-management training</p> <p>0% coinsurance for diabetes supplies</p> <p>0% coinsurance for diabetic therapeutic shoes or inserts</p>	<p><u>In-Network</u> \$0 co-payment for Diabetes Self-Management Training.*</p> <p>\$0 co-payment for:</p> <ul style="list-style-type: none"> - Diabetes monitoring supplies* - Therapeutic shoes or inserts*

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Benefit Category	Original Medicare	Gateway Health Plan Medicare Assured® (HMO SNP)
<p>21. Diagnostic Tests, X-rays, Lab Services, and Radiology Services</p>	<p>0% coinsurance for diagnostic tests and x-rays.</p> <p>\$0 co-payment for Medicare-covered lab services.</p> <p>Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your 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 routine screening tests, like checking your cholesterol.</p> <p>0% coinsurance for the digital rectal exam and other related services</p> <p>Covered once a year for all men with Medicare over age 50.</p>	<p><u>General</u> Authorization rules may apply.</p> <p><u>In-Network</u> \$0 co-payment for Medicare-covered:</p> <ul style="list-style-type: none"> - lab services* - diagnostic procedures and tests* - X-rays* - diagnostic radiology services (not including X-rays).* - therapeutic radiology services*
<p>22. Cardiac and Pulmonary Rehabilitation Services</p>	<p>0% coinsurance for Cardiac Rehabilitation services.</p> <p>0% coinsurance for Pulmonary Rehabilitation services.</p> <p>0% coinsurance for Intensive Cardiac Rehabilitation services.</p> <p>This applies to program services provided in a doctor’s office. Specified cost sharing for program services provided by hospital outpatient departments.</p>	<p><u>General</u> Authorization rules may apply.</p> <p><u>In-Network</u> \$0 co-payment for:</p> <ul style="list-style-type: none"> - Medicare-covered Cardiac Rehabilitation Services* - Medicare-covered Intensive Cardiac Rehabilitation Services* - Medicare-covered Pulmonary Rehabilitation Services*

If you have any questions about this plan’s benefits or costs, please contact Gateway Health Plan Medicare Assured® (HMO SNP) for details.

Benefit Category	Original Medicare	Gateway Health Plan Medicare Assured® (HMO SNP)
PREVENTIVE SERVICES		
<p>23. Preventive Services and Wellness/Education Programs</p>	<p>No coinsurance, co-payment or deductible for the following:</p> <ul style="list-style-type: none"> - Abdominal Aortic Aneurysm Screening. - Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions. - Cardiovascular Screening - Cervical and Vaginal Cancer screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk. - Colorectal Cancer Screening - Diabetes Screening - Influenza Vaccine - Hepatitis B Vaccine for people with Medicare who are at risk. - HIV Screening. \$0 co-payment 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 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. 	<p><u>General</u> \$0 co-payment for all preventive services covered under Original Medicare at zero cost sharing:</p> <ul style="list-style-type: none"> - Abdominal Aortic Aneurysm Screening. - Bone Mass Measurement. - Cardiovascular Screening. - Cervical and Vaginal Cancer screening (Pap Test and Pelvic Exam). - Colorectal Cancer Screening. - Diabetes Screening. - Influenza Vaccine. - Hepatitis B Vaccine. - HIV Screening. - Breast Cancer Screening (Mammogram). - Medical Nutrition Therapy Services. - Personalized Prevention Plan Services. (Annual Wellness Visits) - Pneumococcal Vaccine. - Prostrate Cancer Screening (Prostate Specific Antigen (PSA) test only). - Smoking Cessation (Counseling to stop smoking). - Welcome to Medicare Physical Exam (Initial Preventive Physical Exam). <p>HIV screening is covered for people with Medicare who are pregnant 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. Please contact Plan for details.</p>

If you have any questions about this plan’s benefits or costs, please contact Gateway Health Plan Medicare Assured® (HMO SNP) for details.

Benefit Category	Original Medicare	Gateway Health Plan Medicare Assured® (HMO SNP)
<p>23. Preventive Services and Wellness/Education Programs (cont.)</p>	<p>Medicare covers one baseline mammogram between ages 35-39.</p> <ul style="list-style-type: none"> - 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. - Prostrate Cancer Screening – Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50. - Smoking Cessation (counseling to stop smoking). 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. 	<p><u>In-Network</u> The plan covers the following supplemental education/wellness programs:</p> <ul style="list-style-type: none"> - Written health education materials, including newsletters - Additional Smoking Cessation - Health Club Membership / Fitness Classes

Section 2 – Summary of Benefits

<p>If you have any questions about this plan’s benefits or costs, please contact Gateway Health Plan Medicare Assured® (HMO SNP) for details.</p>		
<p>Benefit Category</p>	<p>Original Medicare</p>	<p>Gateway Health Plan Medicare Assured® (HMO SNP)</p>
<p>23. Preventive Services and Wellness/Education Programs (cont.)</p>	<p>- Welcome to Medicare Physical Exam (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 Physical Exam or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 month.</p>	
<p>24. Kidney Disease and Conditions</p>	<p>0% coinsurance for renal dialysis</p> <p>\$0 coinsurance for kidney disease education services.</p>	<p><u>General</u> Authorization rules may apply</p> <p><u>In-Network</u> \$0 co-payment for renal dialysis.*</p> <p>0% co-payment for kidney disease education services.*</p>
<p>25. Outpatient Prescription Drugs</p>	<p>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.</p>	<p>Drugs covered under Medicare Part B.</p> <p><u>General</u> \$0 year deductible for Part B-covered drugs.*</p> <p>\$0 co-payment for Part B covered chemotherapy drugs and other Part B covered drugs.*</p> <p>Drugs covered under Medicare Part D.</p> <p><u>General</u> This plan uses a formulary. The Plan will send you the formulary. You can also see the formulary at www.GatewayHealthPlan.com/Medicare on the web.</p>

<p>If you have any questions about this plan’s benefits or costs, please contact Gateway Health Plan <i>Medicare Assured</i>[®] (HMO SNP) for details.</p>		
Benefit Category	Original Medicare	Gateway Health Plan <i>Medicare Assured</i> [®] (HMO SNP)
<p>25. Outpatient Prescription Drugs (cont.)</p>		<p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> - have limited incomes, - live in long term care facilities, or have access to Indian/Tribal/Urban (Indian Health Services). <p>Your in-network prescription coverage may be limited to the Plan’s service area. This means that if you travel outside the service area, you may have to pay the full cost of your prescription. In certain emergencies, your drugs will be covered if you get them at an out-of-network pharmacy although you may have to pay additional charges. Contact the Plan for details.</p> <p>Total yearly drug costs are the total drug costs paid by you, the plan, and Medicare.</p> <p>The Plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from Gateway Health Plan <i>Medicare Assured</i>[®] (HMO SNP) for certain drugs.</p> <p>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 Finder on Medicare.gov.</p> <p>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.</p>

Section 2 – Summary of Benefits

<p>If you have any questions about this plan’s benefits or costs, please contact Gateway Health Plan Medicare Assured® (HMO SNP) for details.</p>		
Benefit Category	Original Medicare	Gateway Health Plan Medicare Assured® (HMO SNP)
<p>25. Outpatient Prescription Drugs (cont.)</p>		<p><u>In-Network:</u> You pay \$0 yearly deductible.</p> <p>Initial Coverage Depending on your income and institutional status, you pay the following:</p> <p>For generic drugs (including brand drugs treated as generic), either:</p> <ul style="list-style-type: none"> • A \$0 co-payment; or • A \$1.10 co-payment; or • A \$2.60 co-payment. <p>For all other drugs, either:</p> <ul style="list-style-type: none"> • A \$0 co-payment; or • A \$3.30 co-payment; or • A \$6.50 co-payment. <p>Retail Pharmacy: You can get drugs the following way(s):</p> <ul style="list-style-type: none"> • one-month (30-day) supply. <p>Long term Care Pharmacy: You can get drugs the following way(s):</p> <ul style="list-style-type: none"> • one-month (31-day) supply. <p>Catastrophic Coverage You pay \$0 co-payment.</p> <p><u>Out-of-Network</u> Plan drugs may be covered in special circumstances, for instance, illness while traveling outside 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 Gateway Health Plan Medicare Assured® (HMO SNP).</p> <p>You can get drugs the following way: - one-month (30-day) supply</p>

Section 2 – Summary of Benefits

<p>If you have any questions about this plan’s benefits or costs, please contact Gateway Health Plan <i>Medicare Assured</i>[®] (HMO SNP) for details.</p>		
Benefit Category	Original Medicare	Gateway Health Plan <i>Medicare Assured</i> [®] (HMO SNP)
<p>25. Outpatient Prescription Drugs (cont.)</p>	<p>.</p>	<p><u>Out-of-Network Initial Coverage</u> Depending on your income and institutional status, you will be reimbursed by Gateway Health Plan <i>Medicare Assured</i>[®] (HMO SNP) up to the full cost of the drug minus the following:</p> <p>For generic drugs purchased out-of-network (including brand drugs treated as generic), either:</p> <ul style="list-style-type: none"> • A \$0 co-payment; or • A \$1.10 co-payment; or • A \$2.60 co-payment for generic drugs. <p>For all other drugs purchased out-of-network, either:</p> <ul style="list-style-type: none"> • A \$0 co-payment; or • A \$3.30 co-payment; or • A \$6.50 co-payment. <p><u>Out-of-Network Catastrophic Coverage</u> You be reimbursed in full for drugs purchased out-of-network.</p>
<p>26. Dental Services</p>	<p>Preventive dental services (such as cleaning) not covered.</p>	<p><u>In-Network</u> \$0 co-payment for Medicare-covered dental benefits.*</p> <p>\$0 co-payment for the following preventive dental benefits:</p> <ul style="list-style-type: none"> • Up to 1 oral exam(s) every six months. • Up to 1 cleaning(s) every six months. • Up to 1 dental x-ray(s) every six months. <p>Plan offers additional comprehensive dental benefits.</p> <p>\$500 limit for comprehensive dental benefits every two years.</p> <p>See page 20 for additional information.</p>

Section 2 – Summary of Benefits

<p align="center">If you have any questions about this plan’s benefits or costs, please contact Gateway Health Plan Medicare Assured® (HMO SNP) for details.</p>		
Benefit Category	Original Medicare	Gateway Health Plan Medicare Assured® (HMO SNP)
27. Hearing Services	<p>Supplemental routine hearing exams and hearing aids not covered.</p> <p>0% coinsurance for diagnostic hearing exams.</p>	<p><u>In-Network</u> \$0 co-payment for Medicare-covered diagnostic hearing exams* \$0 co-payment for: - supplemental routine hearing tests - fitting-evaluations for a hearing aid. \$0 co-payment for hearing aids. \$1,000 limit for routine hearing aids every two years. See page 21 for additional information.</p>
28. Vision Services	<p>0% coinsurance for diagnosis and treatment of diseases and conditions of the eye.</p> <p>Supplemental routine eye exams and glasses not covered.</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk.</p>	<p><u>In-Network</u> \$0 co-payment for diagnosis and treatment for diseases and conditions of the eye.* - and up to 1 supplemental routine eye exam(s) every three months. \$0 co-payment for: <ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses after each cataract surgery.* • Up to 1 routine eye exam(s) every three months. • Up to 1 pair(s) of glasses every year, OR • Up to 1 pair(s) of contacts every year. \$150 plan coverage limit for eye wear every year. See page 21 for additional information.</p>
29. Over-the-Counter Items	Not covered	<p><u>General</u> The plan does not cover Over-the-Counter Items</p>
35. Transportation (Routine)	Not covered.	<p><u>General</u> Authorization rules may apply.</p> <p><u>In-Network</u> \$0 co-payment for up to 36 one-way trip(s) to Plan-approved location(s) every year. See page 21 for additional information.</p>
36. Acupuncture	Not covered.	<p><u>In-Network</u> This Plan does not cover Acupuncture.</p>

Focusing on You...Additional Benefits That Make A Difference!

In addition to receiving all the benefits of Original Medicare, as a Gateway Health Plan *Medicare Assured*[®] (HMO SNP) member, you may be eligible to receive **ALL** the following **EXTRA** Benefits at **NO** cost to you!

Highlighted Benefits

Benefit	Cost to Member
Dental Services	\$0*
Transportation Services	\$0*
Monthly Health Plan Premium	\$0*
PCP Visits	\$0*
Specialist Visits	\$0*
Emergency Room Visits	\$0*
Hospitalization	\$0*
Hearing Services	\$0*
Vision Services	\$0*
Wellness Program	\$0
Health Management Programs	\$0

* **Medical Assistance (Medicaid) or the Plan will pay your cost-sharing amounts**



Dental Services

Gateway Health Plan *Medicare Assured*[®] (HMO SNP) recognizes the importance of good dental health. As a member, you are eligible to receive the following:

Routine Dental Services

- One (1) oral exam every six (6) months,
- One (1) cleaning every six (6) months,
- One (1) dental x-ray every six (6) months, and
- One (1) panoramic x-ray every five (5) years.

Comprehensive Dental Services

- Up to \$500 every two (2) years toward minor restorations (such as fillings), simple extractions and denture repair.

Dentures

- One (1) set of dentures every five (5) years.

**If you have any questions, or you would like to have more details about any of these extra benefits please contact: Gateway Health Plan *Medicare Assured*[®] (HMO SNP)
1-877-GATEWAY, (1-877-428-3929), TTY 711.**

Section 3 – Additional Information About Gateway Health Plan *Medicare Assured*[®] (HMO)



Transportation Services

As a Gateway Health Plan *Medicare Assured*[®] (HMO SNP) member, you may receive, at no cost to you:

- 36 one-way trip(s) to Plan-approved locations every calendar year
- Includes non-emergent transportation to doctor visits; dental, vision, hearing, and behavioral health services; and to pharmacies and fitness centers
- Authorization and scheduling rules may apply.

Please contact us at the number at the bottom of this page for details.



Health Management Programs

Gateway Health Plan *Medicare Assured*[®] (HMO SNP) cares about your health and well-being. We believe good service means doing our best to help you stay healthy, lead an active lifestyle, and improve your quality of life.

- Programs to address heart disease, diabetes and asthma.
- Wellness services such as smoking cessation.
- Nurse care managers to help you stay on top of things (qualification apply)



Hearing Services

Is it time to get your hearing checked? GREAT NEWS!

- Routine exams are covered.
- Fittings and evaluations for hearing aids are covered.
- \$1,000 for hearing aids every two (2) years



Vision Services

As a Gateway Health Plan *Medicare Assured*[®] (HMO SNP) member, you are eligible to receive four (4) routine eye exams every calendar year. In addition, Gateway Health Plan *Medicare Assured*[®] (HMO SNP) also provides:

Eyeglasses

- One (1) pair of eyeglasses every calendar year,
- You may receive vendor frames and standard lenses, or
- Receive up to \$90 toward non-vendor frames

OR,

Contacts

- One (1) pair of standard contact lenses every calendar year, or
- Up to \$150 toward specialty contact lenses every calendar year.

**If you have any questions, or you would like to have more details about any of these extra benefits please contact: Gateway Health Plan *Medicare Assured*[®] (HMO SNP)
1-877-GATEWAY, (1-877-428-3929), TTY 711.**



***Fitness Assured*[®] Wellness Program**

As a member of Gateway Health Plan *Medicare Assured*[®] (HMO SNP), you are automatically eligible for our *Fitness Assured*[®] program.

- Is designed to help keep you feeling fit.
- Provides opportunity to enjoy a network of fitness centers and access to resources that promote exercise and a healthy diet.



Bathroom Safety Items

Gateway Health Plan *Medicare Assured*[®] (HMO SNP) can help you make your bathroom a safer place.

- You may receive up to \$100 a calendar year for bathroom safety products (such as bath/shower chairs).

ADDITIONAL INFORMATION ON PLAN BENEFITS

Skilled Nursing Facility

There is a 100 day limit for each skilled nursing facility admission. You must work with your provider to get authorization from Gateway Health Plan *Medicare Assured*[®] (HMO SNP) before you are admitted to a skilled nursing facility. If you do not get authorization, you may be responsible for charges incurred. Contact us at the number below for details.

Gateway Health Plan[®]'s Prospective Care Management PCM[®] Approach

Gateway Health Plan *Medicare Assured*[®] is a Medicare Advantage special needs plan designed for beneficiaries who are eligible for Medicare parts A and B and Medicaid. Your Medicaid eligibility can meet the Full benefit level or Qualified Medicare Beneficiary level (QMB) which has to be determined by your local County Assistance Office.

Gateway Health Plan[®] is more than just a Health plan. We emphasize the development and delivery of innovative programs to positively affect the personal health of its members through our Prospective Care Management (PCM[®]) approach.

Our PCM[®] approach is an enhanced healthcare management model that is offered to Gateway members as a standard component of their healthcare coverage. PCM[®] aims to select and activate interventions that will make a difference in the lives of our members.

**If you have any questions, or you would like to have more details about any of these extra benefits please contact: Gateway Health Plan *Medicare Assured*[®] (HMO SNP)
1-877-GATEWAY, (1-877-428-3929), TTY 711.**

WHY CHOOSE GATEWAY?

Experience - Gateway Health Plan[®] has served the community for 15 + years
- All employees are specifically trained on the PCM[®] approach
- Gateway Health Plan *Medicare Assured*[®] (HMO SNP) specializes in caring for the dual-eligible population

Network - Extensive provider network throughout 28 counties in Pennsylvania.
- 130+ hospitals and more than 10,000 providers
- Board certified doctors

Benefits - The top reason that beneficiaries choose our product.
- Focused on long term value to both existing and new members.

Wondering what our members are saying about Gateway Health Plan *Medicare Assured*[®] (HMO SNP). Check it out!

Reply to a Care Management Outreach Call

“Very satisfied with Gateway Health Plan[®] and likes the fact that we show how much we care. He likes the phone calls to check on him – makes him feel special.”

- Charles McLean, Harrisburg, PA, Gateway member since December, 2010

Mr. Clouse called member services to “Thank everyone for being so professional and assisting him so perfectly. They do a terrific job”.

- Kerry Clouse, Reading, PA, Gateway member since January 2010

As told to a Member Service Representative

Gateway has the best people that he (the member) has worked with. Mr. Annoni is “Happy with Gateway,” has “No Complaints.” (He) Had an accident and Gateway worked with him.

- Gino Annoni, Allentown, PA Gateway member since April 2009

To hear more about the benefits or for more information on how you can become a part of Gateway Health Plan *Medicare Assured*[®] (HMO SNP), visit www.GatewayHealthPlan.com/Medicare or call:

1-877-GATEWAY

(1-877-428-3929)

TTY: 711

8 a.m. – 8 p.m., 7 days a week

Gateway Health Plan *Medicare Assured*[®] (HMO SNP) Looks forward to providing you with
More Than Healthcare.

More Than Healthcare: Serving those with Medicare and Medical Assistance.

Section 4 – Comprehensive Written Statement for Prospective Enrollees

Section Four demonstrates the Medicaid benefit package for full benefit dual-eligible recipients in the Commonwealth of Pennsylvania. The services offered in your Medicaid benefit package are based on your Medicaid eligibility level (Categorically Needy or Medically Needy). Medicare coverage must be used first and the Medicaid Program may cover payment of Medicare Part A and B deductible and coinsurance for all Medicare covered services. The following is a listing of services that may be available in your benefit package through your Medicaid provider:

Doctors or Medical Personnel

- Certified Registered Nurse Practitioner*
- Chiropractors*
- Nurse Midwife*
- Dentist*
 - For Medically Needy recipients, Dental services are only covered in an inpatient or Ambulatory Surgical Center (ASC) and Short Procedure Unit (SPU) setting.
- Optometrist (Eye Doctor)*
- Physician (Medical Doctor) *
- Podiatrist*

Inpatient Services

- Acute Care Hospital
- Drug and Alcohol Facility
- Private Intermediate Care Facility for the Mentally Retarded
- Private Intermediate Care Facility for Other Related Conditions
- Psychiatric Facility
 - Limited up to 30 days per fiscal year. If you need additional services beyond the limit, you or your provider may apply for an exception through the Department of Public Welfare.
- Rehabilitation Hospital Facility
 - One admission per fiscal year. If you need additional services beyond the limit, you or your provider may apply for an exception through the Department of Public Welfare.

Other Settings

- Birthing Centers
- Nursing Facilities

Outpatient Services

- ASC and SPU (Same Day Surgery)
- Federally Qualified Health Center*
- Drug and Alcohol Clinic Services
- Hospital Clinic* and Emergency Room Services
- Psychiatric Clinic
 - Limited up to 5 hours or 10 one-half hour sessions of psychotherapy per recipient in a 30 consecutive day period. If you need additional services beyond the limit, you or your provider may apply for an exception through the Department of Public Welfare.
- Psychiatric Partial Hospitalization Facility
 - Limited up to 180 three-hour sessions, 540 total hours per fiscal year. If you need additional services beyond the limit, you or your provider may apply for an exception through the Department of Public Welfare.
- Independent Medical Surgical Clinic*
- Renal Dialysis Center
- Rural Health Clinic*

Section 4 – Comprehensive Written Statement for Prospective Enrollees

Other Services

- Ambulance
- Family Planning Services
- Home Health (Visiting Nurse)
- Psychiatric Rehabilitation
- Hospice
- Medical Supplies and Equipment
 - For Medically Needy recipients, medical supplies and equipment are only covered when prescribed for the purpose of family planning or in conjunction with Home Health Agency Services.
- Pharmacy
 - For Medically Needy recipients in Long-Term Care limited to legend Barbiturates, Benzodiazepines and certain over-the-counter drugs and vitamins. A legend drug is any drug that requires a prescription.
 - For Categorically Needy recipients limited to legend Barbiturates, Benzodiazepines and certain over-the-counter drugs and vitamins.
- Laboratory
- Portable X-Ray
- Transportation Services
- Peer Specialist Services

Long Term Care Services

- Nursing Home**
- Home and Community Based Waiver Services **
 - Adult Day Living
 - Counseling
 - Environmental Modifications
 - Home Health Care
 - Personal Emergency Response
 - TeleCare
 - Financial Management Services
 - Specialized Medical Equipment and Supplies
 - Participant-Directed Goods and Services
 - Care Coordination
 - Community Transition
 - Home Delivered Meals
 - Personal Care
 - Respite
 - Transportation

*Certain evaluation, management and consultation procedures are limited to a combined maximum of 18 clinic, office and home visits per fiscal year (July 1 through June 30) by physicians, podiatrists, optometrists, certified registered nurse practitioners (CRNP), chiropractors, outpatient hospital clinics, independent medical clinics, rural health clinics and federally qualified health centers (FQHC). Talk with your provider if you have any questions about these procedures. If you need more than 18 visits, you or your provider may ask for an exception through the Department of Public Welfare.

** In order to receive Nursing Home or Home and Community Based Waiver Services, individuals must meet clinical criteria to be considered Nursing Facility Clinically Eligible (NFCE) by the local Area Agency on Aging.

For information about Pennsylvania Medicaid (Medical Assistance) benefits and services:

- Call your local County Assistance Office, or 1-800-842-2020. TDD users may call 1-800-451-5886.
- Visit the Medical Assistance website at www.dpw.state.pa.us.



U.S. Steel Tower, Floor 41
600 Grant Street
Pittsburgh, PA 15219-2704

1-800-685-5209 toll-free
TTY/TDD: 711 for the hearing impaired

8 a.m. - 8 p.m., 7 days a week

www.GatewayHealthPlan.com/Medicare