



## MEDICARE SUPPLEMENT OUTLINE OF BENEFIT COVERAGE

**Shaded Sections show Benefit Plans A, B, C, F, High Deductible F\*, M and N which are available**

These charts show the benefits included in each of the standard Medicare Supplement plans. Every company must make available Plans A, B and C or F. Some plans may not be available in your state.

### Basic Benefits:

- **Hospitalization** - Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses** - Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood** - First three pints of blood each year
- **Hospice** - Part A coinsurance

**Benefit Chart of Medicare Supplement Plans sold on or after June 1, 2010**

A	B	C	D	F	F*	G	K	L	M	N
Basic Including 100% Part B Coinsurance	Basic Including 100% Part B Coinsurance	Basic Including 100% Part B Coinsurance	Basic Including 100% Part B Coinsurance	Basic Including 100% Part B Coinsurance	Basic Including 100% Part B Coinsurance	Basic Including 100% Part B Coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic Including 100% Part B Coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment For office visit, and up to \$50 copayment For ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)	Part B Excess (100%)					
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency				Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit \$4640; paid at 100% after limit reached***	Out-of-pocket limit \$2320; paid at 100% after limit reached***		

\*Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2000 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed \$2000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

**Premium Rate Table 1 (Area 1 = Allegheny; Armstrong; Beaver; Butler; Fayette; Washington; Westmoreland Counties)**

Amounts indicated below are in dollars

**Rating Area 1**

Attained Age	Plan A		Plan B		Plan C		Plan F		Plan F HD		Plan M		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
<65	100.64	97.37	124.57	120.52	147.73	142.93	148.06	143.25	59.47	57.54	122.64	118.65	122.80	118.81
65	100.64	97.37	124.57	120.52	147.73	142.93	148.06	143.25	59.47	57.54	122.64	118.65	122.80	118.81
66	106.43	102.97	131.73	127.45	156.23	151.16	156.58	151.49	62.90	60.85	129.69	125.48	129.86	125.64
67	112.10	108.46	138.76	134.25	164.56	159.22	164.93	159.57	66.25	64.10	136.61	132.17	136.79	132.34
68	117.68	113.85	145.66	140.92	172.75	167.13	173.13	167.50	69.54	67.28	143.40	138.74	143.59	138.92
69	123.17	119.16	152.45	147.50	180.81	174.93	181.20	175.32	72.79	70.42	150.09	145.21	150.29	145.41
70	128.59	124.41	159.16	153.99	188.76	182.63	189.18	183.03	75.99	73.52	156.70	151.60	156.90	151.80
71	133.95	129.60	165.81	160.42	196.64	190.25	197.08	190.67	79.16	76.59	163.24	157.93	163.45	158.14
72	139.29	134.77	172.41	166.81	204.48	197.84	204.93	198.27	82.32	79.64	169.74	164.23	169.97	164.44
73	144.62	139.92	179.01	173.19	212.30	205.41	212.77	205.86	85.47	82.69	176.24	170.51	176.47	170.74
74	149.97	145.10	185.63	179.60	220.15	213.00	220.64	213.47	88.63	85.75	182.75	176.82	182.99	177.05
75	155.36	150.32	192.31	186.06	228.07	220.66	228.57	221.15	91.82	88.83	189.33	183.17	189.58	183.42
76	160.84	155.61	199.08	192.61	236.10	228.43	236.62	228.93	95.05	91.96	195.99	189.63	196.25	189.88
77	166.42	161.01	205.99	199.30	244.30	236.37	244.84	236.89	98.35	95.16	202.80	196.21	203.07	196.47
78	172.16	166.57	213.10	206.17	252.73	244.52	253.29	245.06	101.74	98.44	209.80	202.98	210.07	203.25
79	178.10	172.32	220.45	213.29	261.45	252.96	262.03	253.51	105.26	101.84	217.04	209.99	217.32	210.26
80	184.30	178.31	228.12	220.71	270.55	261.75	271.14	262.33	108.92	105.38	224.58	217.29	224.88	217.57
81	190.80	184.60	236.17	228.49	280.09	270.99	280.71	271.59	112.76	109.10	232.51	224.95	232.82	225.25
82	197.68	191.26	244.68	236.73	290.19	280.76	290.83	281.38	116.82	113.03	240.89	233.06	241.21	233.37
83	205.01	198.34	253.75	245.51	300.94	291.17	301.61	291.81	121.15	117.22	249.82	241.70	250.15	242.02
84	212.86	205.95	263.48	254.92	312.48	302.33	313.17	302.99	125.80	121.71	259.40	250.97	259.74	251.30
85	237.05	229.35	293.42	283.88	347.99	336.68	348.75	337.42	140.09	135.54	288.87	279.49	289.25	279.85
86	237.05	229.35	293.42	283.88	347.99	336.68	348.75	337.42	140.09	135.54	288.87	279.49	289.25	279.85
87	237.05	229.35	293.42	283.88	347.99	336.68	348.75	337.42	140.09	135.54	288.87	279.49	289.25	279.85
88	237.05	229.35	293.42	283.88	347.99	336.68	348.75	337.42	140.09	135.54	288.87	279.49	289.25	279.85
89	237.05	229.35	293.42	283.88	347.99	336.68	348.75	337.42	140.09	135.54	288.87	279.49	289.25	279.85
90	237.05	229.35	293.42	283.88	347.99	336.68	348.75	337.42	140.09	135.54	288.87	279.49	289.25	279.85
91	237.05	229.35	293.42	283.88	347.99	336.68	348.75	337.42	140.09	135.54	288.87	279.49	289.25	279.85
92	237.05	229.35	293.42	283.88	347.99	336.68	348.75	337.42	140.09	135.54	288.87	279.49	289.25	279.85
93	237.05	229.35	293.42	283.88	347.99	336.68	348.75	337.42	140.09	135.54	288.87	279.49	289.25	279.85
94	237.05	229.35	293.42	283.88	347.99	336.68	348.75	337.42	140.09	135.54	288.87	279.49	289.25	279.85
95	237.05	229.35	293.42	283.88	347.99	336.68	348.75	337.42	140.09	135.54	288.87	279.49	289.25	279.85
96	237.05	229.35	293.42	283.88	347.99	336.68	348.75	337.42	140.09	135.54	288.87	279.49	289.25	279.85
97	237.05	229.35	293.42	283.88	347.99	336.68	348.75	337.42	140.09	135.54	288.87	279.49	289.25	279.85
98	237.05	229.35	293.42	283.88	347.99	336.68	348.75	337.42	140.09	135.54	288.87	279.49	289.25	279.85
99+	237.05	229.35	293.42	283.88	347.99	336.68	348.75	337.42	140.09	135.54	288.87	279.49	289.25	279.85

All open enrollment and guaranteed issue insureds will be rated using the Preferred rates above.

Apply a factor of 1.25 for Standard 1 Class rates

Apply a factor of 1.50 for Standard 2 Class rates

**Premium Rate Table 2 (Area 2 – Bucks; Chester; Delaware, Montgomery & Philadelphia Counties)**

Amounts indicated below are in dollars

**Rating Area 2**

Attained Age	Plan A		Plan B		Plan C		Plan F		Plan F HD		Plan M		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
<65	103.44	100.08	124.49	120.44	146.84	142.07	147.18	142.40	59.13	57.21	123.20	119.20	121.83	117.87
65	103.44	100.08	124.49	120.44	146.84	142.07	147.18	142.40	59.13	57.21	123.20	119.20	121.83	117.87
66	109.40	105.84	131.65	127.37	155.29	150.25	155.64	150.59	62.53	60.50	130.29	126.06	128.83	124.65
67	115.23	111.48	138.67	134.17	163.57	158.26	163.94	158.62	65.86	63.72	137.24	132.78	135.70	131.30
68	120.96	117.03	145.57	140.84	171.71	166.13	172.10	166.51	69.14	66.89	144.06	139.38	142.45	137.82
69	126.60	122.49	152.36	147.41	179.72	173.88	180.13	174.27	72.36	70.01	150.79	145.89	149.10	144.25
70	132.17	127.88	159.06	153.89	187.63	181.53	188.05	181.94	75.55	73.09	157.42	152.31	155.66	150.60
71	137.69	133.22	165.70	160.32	195.46	189.11	195.90	189.54	78.70	76.14	163.99	158.66	162.16	156.89
72	143.18	138.53	172.31	166.71	203.25	196.64	203.71	197.09	81.84	79.18	170.53	164.99	168.62	163.14
73	148.66	143.83	178.90	173.09	211.02	204.17	211.50	204.63	84.97	82.21	177.05	171.30	175.07	169.38
74	154.15	149.14	185.52	179.49	218.83	211.72	219.32	212.20	88.11	85.25	183.60	177.63	181.55	175.65
75	159.70	154.51	192.19	185.94	226.70	219.33	227.21	219.83	91.28	88.31	190.20	184.02	188.07	181.96
76	165.32	159.95	198.96	192.49	234.68	227.06	235.22	227.57	94.49	91.42	196.90	190.50	194.70	188.37
77	171.06	165.51	205.87	199.18	242.83	234.94	243.38	235.48	97.78	94.60	203.74	197.12	201.46	194.92
78	176.96	171.21	212.97	206.05	251.21	243.05	251.78	243.60	101.15	97.86	210.77	203.92	208.41	201.64
79	183.07	177.12	220.32	213.16	259.88	251.43	260.47	252.01	104.64	101.24	218.04	210.96	215.60	208.60
80	189.44	183.28	227.98	220.57	268.92	260.18	269.53	260.77	108.28	104.76	225.62	218.29	223.10	215.85
81	196.12	189.75	236.02	228.35	278.40	269.36	279.04	269.97	112.10	108.46	233.59	226.00	230.97	223.47
82	203.19	196.59	244.53	236.59	288.44	279.07	289.10	279.70	116.14	112.37	242.01	234.14	239.30	231.52
83	210.72	203.88	253.59	245.35	299.13	289.41	299.81	290.07	120.44	116.53	250.98	242.82	248.17	240.10
84	218.80	211.69	263.32	254.76	310.60	300.51	311.31	301.19	125.06	121.00	260.60	252.13	257.68	249.31
85	243.66	235.75	293.24	283.71	345.89	334.65	346.68	335.41	139.27	134.75	290.21	280.78	286.96	277.64
86	243.66	235.75	293.24	283.71	345.89	334.65	346.68	335.41	139.27	134.75	290.21	280.78	286.96	277.64
87	243.66	235.75	293.24	283.71	345.89	334.65	346.68	335.41	139.27	134.75	290.21	280.78	286.96	277.64
88	243.66	235.75	293.24	283.71	345.89	334.65	346.68	335.41	139.27	134.75	290.21	280.78	286.96	277.64
89	243.66	235.75	293.24	283.71	345.89	334.65	346.68	335.41	139.27	134.75	290.21	280.78	286.96	277.64
90	243.66	235.75	293.24	283.71	345.89	334.65	346.68	335.41	139.27	134.75	290.21	280.78	286.96	277.64
91	243.66	235.75	293.24	283.71	345.89	334.65	346.68	335.41	139.27	134.75	290.21	280.78	286.96	277.64
92	243.66	235.75	293.24	283.71	345.89	334.65	346.68	335.41	139.27	134.75	290.21	280.78	286.96	277.64
93	243.66	235.75	293.24	283.71	345.89	334.65	346.68	335.41	139.27	134.75	290.21	280.78	286.96	277.64
94	243.66	235.75	293.24	283.71	345.89	334.65	346.68	335.41	139.27	134.75	290.21	280.78	286.96	277.64
95	243.66	235.75	293.24	283.71	345.89	334.65	346.68	335.41	139.27	134.75	290.21	280.78	286.96	277.64
96	243.66	235.75	293.24	283.71	345.89	334.65	346.68	335.41	139.27	134.75	290.21	280.78	286.96	277.64
97	243.66	235.75	293.24	283.71	345.89	334.65	346.68	335.41	139.27	134.75	290.21	280.78	286.96	277.64
98	243.66	235.75	293.24	283.71	345.89	334.65	346.68	335.41	139.27	134.75	290.21	280.78	286.96	277.64
99+	243.66	235.75	293.24	283.71	345.89	334.65	346.68	335.41	139.27	134.75	290.21	280.78	286.96	277.64

All open enrollment and guaranteed issue insureds will be rated using the Preferred rates above.

Apply a factor of 1.25 for Standard 1 Class rates

Apply a factor of 1.50 for Standard 2 Class rates

**Premium Rate Table 3 (Area 3 = Adams, Bedford, Berks, Blair, Bradford, Cambria, Cameron, Carbon, Centre, Clarion, Clearfield, Clinton, Columbia, Crawford, Cumberland, Dauphin, Elk, Erie, Forest, Franklin, Fulton, Greene, Huntingdon, Indiana, Jefferson, Juniata, Lackawanna, Lancaster, Lawrence, Lebanon, Lehigh, Luzerne, Lycoming, McKean, Mercer, Mifflin, Monroe, Montour, Northampton, Northumberland, Perry, Pike, Potter, Schuylkill, Snyder, Somerset, Sullivan, Susquehanna, Tioga, Union, Venango, Warren, Wayne, Wyoming and York)**

Amounts indicated below are in dollars

**Rating Area 3**

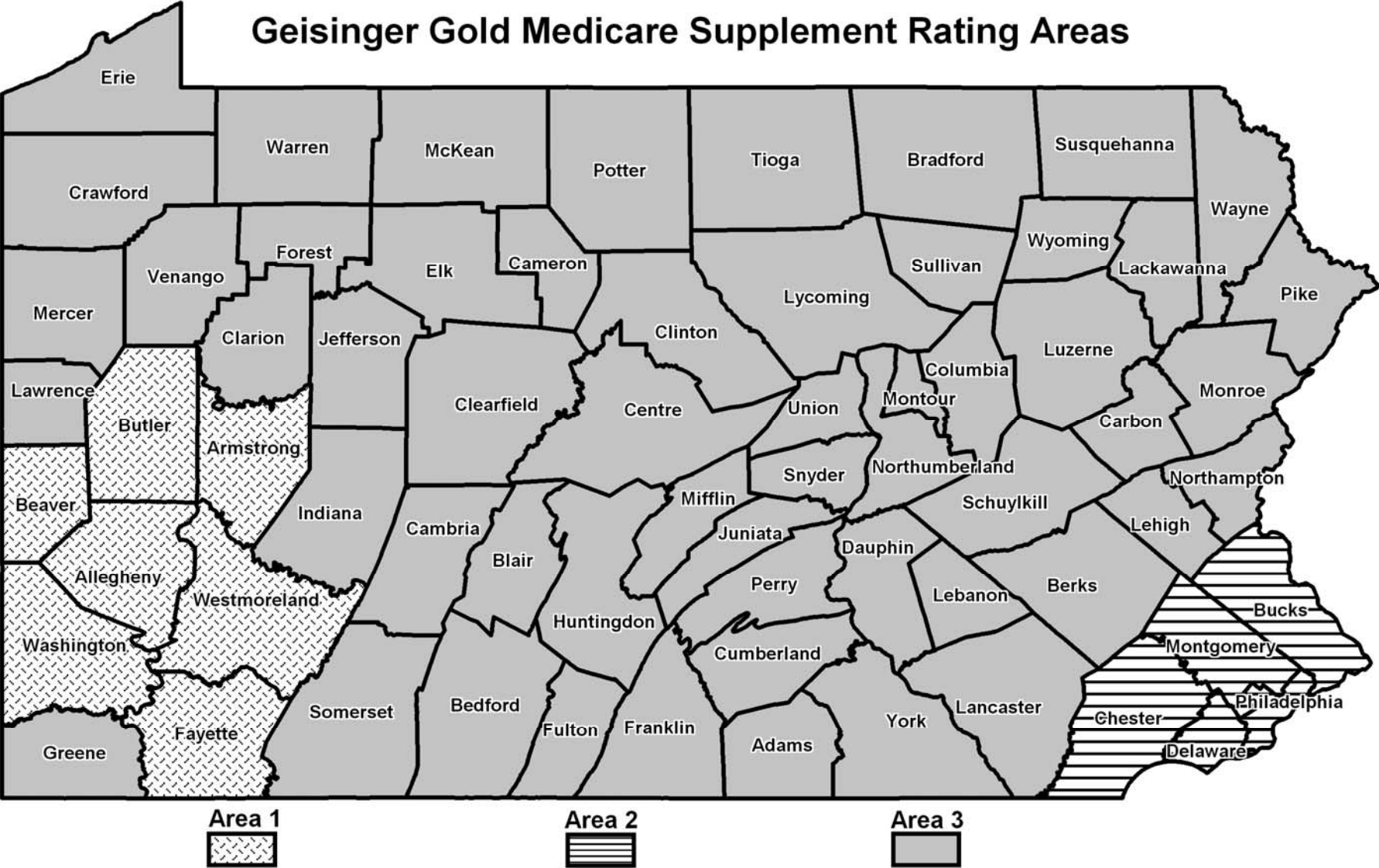
Attained Age	Plan A		Plan B		Plan C		Plan F		Plan F HD		Plan M		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
<65	84.62	81.87	101.93	98.62	122.89	118.90	123.16	119.15	49.77	48.15	101.66	98.36	100.62	97.35
65	84.62	81.87	101.93	98.62	122.89	118.90	123.16	119.15	49.77	48.15	101.66	98.36	100.62	97.35
66	89.49	86.58	107.80	104.30	129.96	125.74	130.24	126.01	52.63	50.92	107.51	104.01	106.41	102.95
67	94.26	91.20	113.55	109.86	136.89	132.45	137.18	132.73	55.44	53.64	113.24	109.56	112.08	108.44
68	98.95	95.73	119.19	115.32	143.70	139.03	144.01	139.33	58.19	56.30	118.87	115.01	117.66	113.83
69	103.57	100.20	124.75	120.70	150.41	145.52	150.72	145.83	60.91	58.93	124.42	120.37	123.15	119.14
70	108.12	104.61	130.24	126.01	157.02	151.92	157.36	152.24	63.59	61.52	129.89	125.67	128.56	124.39
71	112.64	108.98	135.68	131.27	163.58	158.26	163.93	158.60	66.24	64.09	135.31	130.92	133.93	129.58
72	117.13	113.32	141.09	136.50	170.10	164.57	170.46	164.92	68.88	66.65	140.71	136.13	139.27	134.74
73	121.61	117.66	146.49	141.73	176.61	170.87	176.98	171.23	71.52	69.20	146.09	141.34	144.60	139.90
74	126.10	122.01	151.90	146.97	183.14	177.19	183.53	177.56	74.16	71.76	151.49	146.57	149.95	145.07
75	130.64	126.39	157.37	152.25	189.72	183.56	190.13	183.95	76.83	74.34	156.94	151.84	155.34	150.29
76	135.24	130.85	162.91	157.61	196.41	190.02	196.82	190.43	79.54	76.95	162.47	157.19	160.81	155.58
77	139.94	135.39	168.57	163.09	203.23	196.62	203.66	197.04	82.30	79.63	168.11	162.65	166.39	160.99
78	144.76	140.06	174.38	168.72	210.24	203.41	210.68	203.84	85.14	82.37	173.91	168.26	172.13	166.54
79	149.76	144.89	180.40	174.54	217.49	210.43	217.95	210.87	88.08	85.22	179.91	174.07	178.07	172.29
80	154.97	149.93	186.67	180.61	225.06	217.74	225.53	218.21	91.14	88.18	186.17	180.12	184.27	178.28
81	160.44	155.22	193.26	186.98	233.00	225.43	233.49	225.91	94.36	91.29	192.74	186.47	190.77	184.57
82	166.22	160.82	200.23	193.72	241.40	233.55	241.91	234.05	97.76	94.58	199.68	193.20	197.65	191.22
83	172.38	166.78	207.65	200.90	250.34	242.21	250.88	242.72	101.38	98.09	207.09	200.36	204.97	198.31
84	178.99	173.17	215.61	208.60	259.94	251.50	260.49	252.03	105.27	101.85	215.03	208.04	212.83	205.91
85	199.33	192.85	240.11	232.30	289.48	280.07	290.09	280.67	117.23	113.42	239.46	231.68	237.01	229.31
86	199.33	192.85	240.11	232.30	289.48	280.07	290.09	280.67	117.23	113.42	239.46	231.68	237.01	229.31
87	199.33	192.85	240.11	232.30	289.48	280.07	290.09	280.67	117.23	113.42	239.46	231.68	237.01	229.31
88	199.33	192.85	240.11	232.30	289.48	280.07	290.09	280.67	117.23	113.42	239.46	231.68	237.01	229.31
89	199.33	192.85	240.11	232.30	289.48	280.07	290.09	280.67	117.23	113.42	239.46	231.68	237.01	229.31
90	199.33	192.85	240.11	232.30	289.48	280.07	290.09	280.67	117.23	113.42	239.46	231.68	237.01	229.31
91	199.33	192.85	240.11	232.30	289.48	280.07	290.09	280.67	117.23	113.42	239.46	231.68	237.01	229.31
92	199.33	192.85	240.11	232.30	289.48	280.07	290.09	280.67	117.23	113.42	239.46	231.68	237.01	229.31
93	199.33	192.85	240.11	232.30	289.48	280.07	290.09	280.67	117.23	113.42	239.46	231.68	237.01	229.31
94	199.33	192.85	240.11	232.30	289.48	280.07	290.09	280.67	117.23	113.42	239.46	231.68	237.01	229.31
95	199.33	192.85	240.11	232.30	289.48	280.07	290.09	280.67	117.23	113.42	239.46	231.68	237.01	229.31
96	199.33	192.85	240.11	232.30	289.48	280.07	290.09	280.67	117.23	113.42	239.46	231.68	237.01	229.31
97	199.33	192.85	240.11	232.30	289.48	280.07	290.09	280.67	117.23	113.42	239.46	231.68	237.01	229.31
98	199.33	192.85	240.11	232.30	289.48	280.07	290.09	280.67	117.23	113.42	239.46	231.68	237.01	229.31
99+	199.33	192.85	240.11	232.30	289.48	280.07	290.09	280.67	117.23	113.42	239.46	231.68	237.01	229.31

All open enrollment and guaranteed issue insureds will be rated using the Preferred rates above.

Apply a factor of 1.25 for Standard 1 Class rates

Apply a factor of 1.50 for Standard 2 Class rates

# Geisinger Gold Medicare Supplement Rating Areas



## **PREMIUM INFORMATION**

We, Geisinger Indemnity Insurance Company, can only raise your premium if we raise the premium for all policies like yours in the same age, classification and rating area of the Commonwealth of Pennsylvania. Subject to the approval of the Pennsylvania Insurance Department, the Plan may change the premium rate paid by all Policyholders covered under this Policy: 1) based on the current attained age of the Policyholder and/or 2) if the Plan raises the premium rate for all the Policyholders who reside in the same classification or rating area of the state.

## **DISCLOSURES**

Use this outline to compare benefits and premiums among policies.

## **READ YOUR POLICY VERY CAREFULLY**

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

## **RIGHT TO RETURN POLICY**

If you find that you are not satisfied with your policy, you may return it to Geisinger Indemnity Insurance Company at 100 North Academy Avenue, Danville, PA 17822. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

## **POLICY REPLACEMENT**

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

## **NOTICE**

This policy may not fully cover all of your medical costs.

Geisinger Indemnity Insurance Company and its agents are not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult Medicare and You for more details.

## **COMPLETE ANSWERS ARE VERY IMPORTANT**

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

**GEISINGER GOLD MEDICARE SUPPLEMENT PLAN A**

**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies - First 60 days - 61 <sup>st</sup> through 90 <sup>th</sup> day - 91 <sup>st</sup> day and after: -- while using 60 lifetime reserve days -- once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$1,132 All but \$283 a day All but \$566 a day \$0 \$0	\$0 \$283 a day \$566 a day 100% of Medicare eligible expenses \$0	\$1,132 (Part A deductible) \$0 \$0 \$0** All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility. Within 30 days after leaving the hospital: - First 20 days - 21 <sup>st</sup> through 100 <sup>th</sup> day - 101 <sup>st</sup> day and after	All approved amounts All but \$141.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$141.50 a day All costs
<b>BLOOD</b> - First 3 pints - Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

\*\***NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**GEISINGER GOLD MEDICARE SUPPLEMENT PLAN A**

**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

\*Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
- First \$162 of Medicare Approved Amounts*	\$0	\$0	\$162 (Part B deductible)
- Remainder of Medical Approved Amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b>			
- First 3 pints	\$0	All costs	\$0
- Next \$162 of Medicare Approved Amounts*	\$0	\$0	\$162 (Part B deductible)
- Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES</b> -TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A and B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTHCARE</b> <b>MEDICARE APPROVED SERVICES</b>			
- Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- Durable medical equipment			
- First \$162 of Medicare Approved Amounts*	\$0	\$0	\$162 (Part B deductible)
- Remainder of Medicare Approved Amounts	80%	20%	\$0



**GEISINGER GOLD MEDICARE SUPPLEMENT PLAN B**

**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies: - First 60 days - 61 <sup>st</sup> through 90 <sup>th</sup> day - 91 <sup>st</sup> day and after: -- While using 60 lifetime reserve days -- Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$1,132 All but \$283 a day All but \$566 a day \$0 \$0	\$1,132 (Part A deductible) \$283 a day \$566 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital. -First 20 days -21 <sup>st</sup> through 100 <sup>th</sup> day -101 <sup>st</sup> day and after	All approved amounts All but \$141.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$141.50 a day All costs
<b>BLOOD</b> -First 3 pints -Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

\*\*NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**GEISINGER GOLD MEDICARE SUPPLEMENT PLAN B**

**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

\*Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUT-PATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: -- First \$162 of Medicare Approved Amounts*  -- Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$0  Generally 20%	\$162 (Part B deductible)  \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> - First 3 pints  - Next \$162 of Medicare Approved Amounts*  - Remainder of Medicare Approved Amounts	\$0  \$0  80%	All costs  \$0  20%	\$0  \$162 (Part B deductible)  \$0
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A AND B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTHCARE MEDICARE APPROVED SERVICES</b> -Medically necessary skilled care services and medical supplies - Durable medical equipment -- First \$162 of Medicare Approved Amounts* -- Remainder of Medicare Approved Amounts	100%  \$0  80%	\$0  \$0  20%	\$0  \$162 (Part B deductible)  \$0

**GEISINGER GOLD MEDICARE SUPPLEMENT PLAN C**

**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

\*A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies - First 60 days - 61 <sup>st</sup> through 90 <sup>th</sup> day - 91 <sup>st</sup> day and after: -- While using 60 lifetime reserve days -- Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$1,132 All but \$283 a day All but \$566 a day \$0 \$0	\$1,132 (Part A deductible) \$283 a day \$566 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital - First 20 days - 21 <sup>st</sup> through 100 <sup>th</sup> day - 101 <sup>st</sup> day and after	All approved amounts All but \$141.50 a day \$0	\$0 Up to \$141.50 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> - First 3 pints - Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	Balance

\*\*NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**GEISINGER GOLD MEDICARE SUPPLEMENT PLAN C**

**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

\*Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: - First \$162 of Medicare Approved Amounts* - Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$162 (Part B deductible) Generally 20%	 \$0 \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> - First 3 pints - Next \$162 of Medicare Approved Amounts* - Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$162 (Part B deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A AND B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTHCARE MEDICARE APPROVED SERVICES</b> - Medically necessary skilled care services and medical supplies - Durable medical equipment -- First \$162 of Medicare Approved Amounts* -- Remainder of Medicare Approved Amounts	100%  \$0 80%	 \$0 \$162 (Part B deductible) 20%	 \$0 \$0 \$0

**GEISINGER GOLD MEDICARE SUPPLEMENT PLAN C**

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<p><b>FOREIGN TRAVEL—NOT COVERED BY MEDICARE</b>                      Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA</p> <ul style="list-style-type: none"> <li>- First \$250 each calendar year</li> <li>- Remainder of charges</li> </ul>	<p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>80% to a lifetime maximum benefit of \$50,000</p>	<p>\$250</p> <p>20% and amounts over the \$50,000 lifetime maximum</p>

## GEISINGER GOLD MEDICARE SUPPLEMENT PLAN F

### MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies - First 60 days - 61 <sup>st</sup> through 90 <sup>th</sup> day - 91 <sup>st</sup> day and after: -- While using 60 lifetime reserve days -- Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$1,132 All but \$283 a day  All but \$566 a day  \$0  \$0	\$1,132 (Part A deductible) \$283 a day  \$566 a day  100% of Medicare eligible expenses \$0	\$0 \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: - First 20 days  - 21 <sup>st</sup> through 100 <sup>th</sup> day  - 101 <sup>st</sup> day and after	All approved amounts  All but \$141.50 a day  \$0	\$0  Up to \$141.50 a day  \$0	\$0  \$0  All costs
<b>BLOOD</b> - First 3 pints - Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**GEISINGER GOLD MEDICARE SUPPLEMENT PLAN F**

**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

\*Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: - First \$162 of Medicare Approved Amounts*  - Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$162 (Part B deductible)  Generally 20%	\$0  \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> - First 3 pints  - Next \$162 of Medicare Approved Amounts*  - Remainder of Medicare Approved Amounts	\$0  \$0  80%	All costs  \$162 (Part B deductible)  20%	\$0  \$0  \$0
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

## GEISINGER GOLD MEDICARE SUPPLEMENT PLAN F

### PARTS A AND B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTHCARE</b>			
<b>MEDICARE APPROVED SERVICES</b>			
- Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- Durable medical equipment			
-- First \$162 of Medicare Approved Amounts*	\$0	\$162 (Part B deductible)	\$0
-- Remainder of Medicare Approved Amounts	80%	20%	\$0

### OTHER BENEFITS—NOT COVERED BY MEDICARE

<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
- First \$250 each calendar year	\$0	\$0	\$250
- Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum



**GEISINGER GOLD MEDICARE SUPPLEMENT HIGH DEDUCTIBLE PLAN F**

**MEDICARE (PART B)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

\*Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

\*\*This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,000 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan’s separate foreign travel emergency deductible.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>(AFTER YOU PAY \$2,000 DEDUCTIBLE,**) PLAN PAYS</b>	<b>(IN ADDITION TO \$2,000 DEDUCTIBLE,**) YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies - First 60 days - 61 <sup>st</sup> through 90 <sup>th</sup> day - 91 <sup>st</sup> day and after: -- While using 60 lifetime reserve days -- Once lifetime reserve days are used: - Additional 365 days  - Beyond the additional 365 days	All but \$1,132 All but \$283 a day  All but \$566 a day  \$0  \$0	\$1,132 (Part A deductible) \$283 a day  \$566 a day  100% of Medicare eligible expenses \$0	\$0 \$0  \$0  \$0***  All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: - First 20 days  - 21 <sup>st</sup> through 100 <sup>th</sup> day  - 101 <sup>st</sup> day and after	All approved amounts  All but \$141.50 a day  \$0	\$0  Up to \$141.50 a day  \$0	\$0  \$0  All costs
<b>BLOOD</b> - First 3 pints - Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

\*\*\* **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**GEISINGER GOLD MEDICARE SUPPLEMENT HIGH DEDUCTIBLE PLAN F**

**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

\*Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

\*\*This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,000 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan’s separate foreign travel emergency deductible.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>(AFTER YOU PAY \$2,000 DEDUCTIBLE,**) PLAN PAYS</b>	<b>(IN ADDITION TO \$2,000 DEDUCTIBLE,**) YOU PAY</b>
<b>MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: - First \$162 of Medicare Approved Amounts*  - Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$162 (Part B deductible)  Generally 20%	\$0  \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> - First 3 pints  - Next \$162 of Medicare Approved Amounts  - Remainder of Medicare Approved Amounts	\$0  \$0  80%	All costs  \$162 (Part B deductible)  20%	\$0  \$0  \$0
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**GEISINGER GOLD MEDICARE SUPPLEMENT HIGH DEDUCTIBLE PLAN F**

**PARTS A AND B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>(AFTER YOU PAY \$2,000 DEDUCTIBLE,**) PLAN PAYS</b>	<b>(IN ADDITION TO \$2,000 DEDUCTIBLE,**) YOU PAY</b>
<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b>			
- Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- Durable medical equipment: -- First \$162 of Medicare Approved Amounts*	\$0	\$162 (Part B deductible)	\$0
-- Remainder of Medicare Approved Amounts	80%	20%	\$0

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>(AFTER YOU PAY \$2,000 DEDUCTIBLE,**) PLAN PAYS</b>	<b>(IN ADDITION TO \$2,000 DEDUCTIBLE,**) YOU PAY</b>
<b>FOREIGN TRAVEL—NOT COVERED BY MEDICARE</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA:			
- First \$250 each calendar year	\$0	\$0	\$250
- Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

## GEISINGER GOLD MEDICARE SUPPLEMENT PLAN M

### MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies: - First 60 days - 61 <sup>st</sup> through 90 <sup>th</sup> day - 91 <sup>st</sup> day and after: -- While using 60 lifetime reserve days -- Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$1,132  All but \$283 a day  All but \$566 a day  \$0  \$0	\$566 (50% of Part A deductible) \$283 a day  \$566 a day  100% of Medicare eligible expenses \$0	\$566 (50% of Part A deductible) \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: - First 20 days - 21 <sup>st</sup> through 100 <sup>th</sup> day - 101 <sup>st</sup> day and after	All approved amounts All but \$141.50 a day \$0	\$0 Up to \$141.50 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> - First 3 pints - Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**GEISINGER GOLD MEDICARE SUPPLEMENT PLAN M**

**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

\*Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT,</b> such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: - First \$162 of Medicare Approved Amounts*  - Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$0  Generally 20%	\$162 (Part B deductible)  Generally \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> - First 3 pints  - Next \$162 of Medicare Approved Amounts*  - Remainder of Medicare Approved Amounts	\$0  \$0  80%	All costs  \$0  20%	\$0  \$162 (Part B deductible)  \$0
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A AND B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTHCARE</b> MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment: -- First \$162 of Medicare Approved Amounts*  -- Remainder of Medicare Approved Amounts	100%  \$0  80%	\$0  \$0  20%	\$0  \$162 (Part B deductible)  \$0

**GEISINGER GOLD MEDICARE SUPPLEMENT PLAN M**

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>FOREIGN TRAVEL—NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA: - First \$250 each calendar year	\$0	\$0	\$250
- Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

## GEISINGER GOLD MEDICARE SUPPLEMENT PLAN N

### MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies: - First 60 days  - 61 <sup>st</sup> through 90 <sup>th</sup> day  - 91 <sup>st</sup> day and after: -- While using 60 lifetime reserve days -- Once lifetime reserve days are used: - Additional 365 days  - Beyond the additional 365 days	All but \$1,132  All but \$283 a day  All but \$566 a day  \$0  \$0	\$1,132 (Part A deductible)  \$283 a day  \$566 a day  100% of Medicare eligible expenses \$0	\$0  \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: - First 20 days - 21 <sup>st</sup> through 100 <sup>th</sup> day - 101 <sup>st</sup> day and after	All approved amounts All but \$141.50 a day \$0	\$0 Up to \$141.50 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> - First 3 pints - Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

\*\* **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**GEISINGER GOLD MEDICARE SUPPLEMENT PLAN N**

**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

\*Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT,</b> such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: - First \$162 of Medicare Approved Amounts* - Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$0  Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The co-payment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	\$162 (Part B deductible)  up to \$20 per office visit and up to \$50 per emergency room visit. The co-payment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> - First 3 pints - Next \$162 of Medicare Approved Amounts* - Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$162 (Part B deductible) \$0
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0



**GEISINGER GOLD MEDICARE SUPPLEMENT PLAN N**

**PARTS A AND B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTHCARE MEDICARE APPROVED SERVICES</b>			
- Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- Durable medical equipment:			
-- First \$162 of Medicare Approved Amounts*	\$0	\$0	\$162 (Part B deductible)
-- Remainder of Medicare Approved Amounts	80%	20%	\$0

**PLAN M**

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>FOREIGN TRAVEL—NOT COVERED BY MEDICARE</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA:			
- First \$250 each calendar year	\$0	\$0	\$250
- Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum