## GEISINGER GOLD®

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

<sup>\*</sup>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	Pla	an A	Pla	an B	Pla	an C		an F	Plan	F HD	Pla	an M	Pla	ın N
Age	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

Ratin	a A	rea	2

Attained	Pla	an A	Pla	an B	Pla	an C		an F	Plan	F HD	Pla	an M	Pla	an N
Age	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)

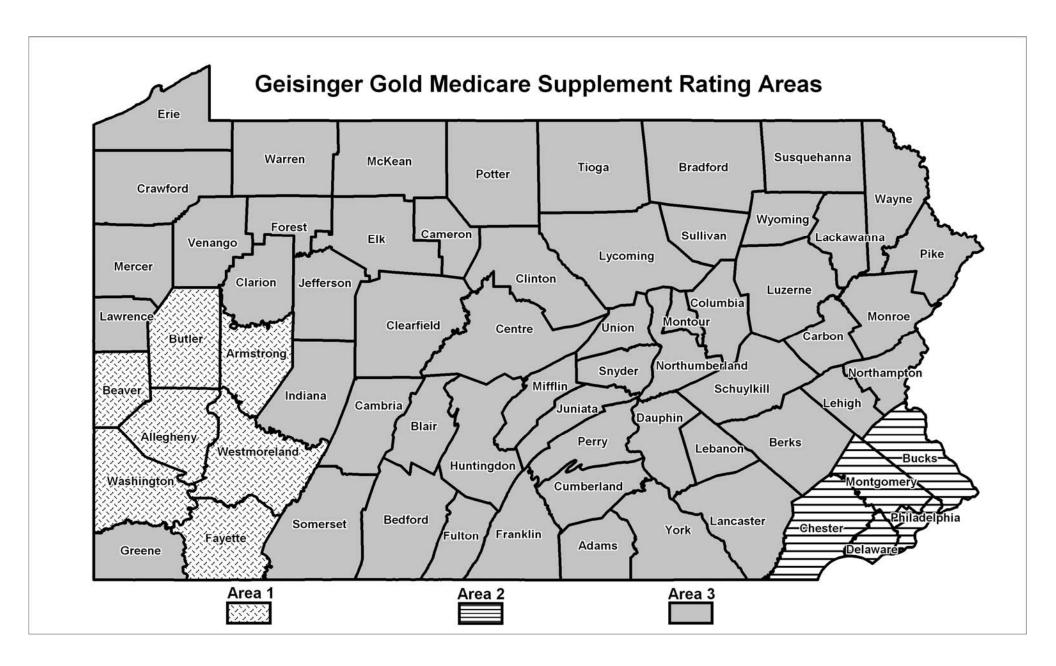
#### Amounts indicated below are in dollars Rating Area 3

Attained	Pla	an A	Pla	an B	Pla	an C		an F	Plan	FHD	Pla	an M	Pla	n N
Age	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



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#### 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.

HOSPITALIZATION® Semiprivate room and board, general nursing and miscellaneous services and supplies - First 60 days  All but \$1,132  \$0  \$1,132 (Part A deductible)  \$1,132 (Part A deductible)  All but \$283 a day  \$0  \$1,132 (Part A deductible)  \$0  \$1,132 (Part A deductible)  \$1,1	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
Semiprivate room and board, general nursing and miscellaneous services and supplies  - First 60 days  - All but \$1,132  \$0 \$1,132 (Part A deductible)  - 61" through 90" day  - 91" day and after:  - while using 60 lifetime reserve days  - once lifetime reserve days  - once lifetime reserve days  - additional 365 days  - Beyond the additional 365 days  - Bracellary CARE*  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 bospital: - First 20 days  - 21" through 100" day  - 101" day and after  \$0 \$0 \$0 \$0  All costs  S0 \$0 \$0  First 3 pints  - Additional amounts  NO \$0 \$0  S0				1001111
general nursing and miscellaneous services and supplies - First 60 days - All but \$1,132 - 61st through 90th day - 91st day and after: while using 60 lifetime reserve days - once lifetime reserve days - once lifetime reserve days - Additional 365 days - Beyond the additional 365 days - Bround				
miscellaneous services and supplies - First 60 days - G1 <sup>st</sup> through 90 <sup>th</sup> day - G1 <sup>st</sup> through 90 <sup>th</sup> day - All but \$283 a day - S283 a day - S283 a day - S283 a day - S384 a day - S384 a day - S385 a day - S485 a day - S566 a day - S566 a day - S566 a day - S666 a day - S668 a day - S666	•			
- First 60 days  All but \$1,132  \$0  \$1,132 (Part A deductible)  All but \$283 a day  \$0  \$1,132 (Part A deductible)  All but \$283 a day  \$0  \$0  \$1,132 (Part A deductible)  \$0  \$0  \$0  \$0  \$0  \$0  \$0  \$0  \$1,132 (Part A deductible)  \$0  \$0  \$0  \$0  \$0  \$1,132 (Part A deductible)  \$0  \$0  \$0  \$0  \$0  \$0  \$0  \$0  \$0  \$	miscellaneous services and			
- 61st through 90th day - 91st day and after:	supplies			
- 91st day and after: - while using 60 lifetime reserve days once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days - Beyond the additional 365 days - Beyond the additional 365 days  SKILLED NURSING FACILITY CARE* 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  All approved amounts  S0  S0  S0  All costs  S0  S0  S0  S0  All costs  S0  All approved amounts S0  S0  Up to \$141.50 a day S1  S1  S1  S1  S1  S1  S2  S4  S4  S4  S5  S6  S6  S6  S6  S7  S8  S8  S8  S8  S8  S8  S8  S8  S8	- First 60 days	All but \$1,132	\$0	\$1,132 (Part A deductible)
- while using 60 lifetime reserve days - once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days - Beyond the additional 365 days  - Beyond the additional 365 days  - Beyond the additional 365 days  - SKILLED NURSING FACILITY CARE* 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  - 21st through 100th day - All but \$141.50 a day  S0  All costs  All approved amounts  S0  Up to \$141.50 a day  All costs  BLOOD - First 3 pints - Additional amounts  S0  All but very limited copayment/coinsurance doctor's certification of for out-patient drugs and doctor's certification of for out-patient drugs and doctor's certification of	- 61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$283 a day	\$283 a day	\$0
- while using 60 lifetime reserve days - once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days - Beyond the additional 365 days  - Beyond the additional 365 days  - Beyond the additional 365 days  - SKILLED NURSING FACILITY CARE* 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  - 21st through 100th day - All but \$141.50 a day  S0  All costs  All approved amounts  S0  Up to \$141.50 a day  All costs  BLOOD - First 3 pints - Additional amounts  S0  3 pints S0  Wedicare copayment/coinsurance for out-patient drugs and doctor's certification of for out-pa	- 91 <sup>st</sup> day and after:			
reserve days once lifetime reserve days are used: - Additional 365 days  Beyond the additional 365 days  Beyond the additional 365 days  SKILLED NURSING FACILITY CARE* 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  - 21st through 100th day - 101st day and after  BLOOD - First 3 pints - Additional amounts  S0  3 pints - Additional amounts  S0  4 pto \$0  4 pto \$141.50 a day  All costs  BLOOD - First 3 pints - Additional amounts - All but very limited copayment/coinsurance for out-patient drugs and doctor's certification of for out-patient drugs and		All but \$566 a day	\$566 a day	\$0
once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days  SKILLED NURSING FACILITY CARE* 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 - 21st through 100th day - 101st day and after  BLOOD - First 3 pints - Additional amounts - First 3 pints - Additional amounts - All but very limited copayment/coinsurance doctor's certification of for out-patient drugs and	_		42 3 5 th 2 th	
- Additional 365 days  - Beyond the additional 365 days  SKILLED NURSING FACILITY CARE* 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  S0  All approved amounts  S0  S0  Up to \$141.50 a day  Up to \$141.50 a day  All costs  BLOOD - First 3 pints - Additional amounts  100%  All but very limited copayment/coinsurance for out-patient drugs and doctor's certification of  Medicare copayment/coinsurance for out-patient drugs and				
- Beyond the additional 365 days  SKILLED NURSING FACILITY CARE* 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  - 21st through 100th day  - 101st day and after  S0  All approved amounts  S0  S0  Up to \$141.50 a day  Up to \$141.50 a day  All costs  BLOOD  - First 3 pints - Additional amounts  100%  HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of  All but very limited copayment/coinsurance for out-patient drugs and	days are used:			
Beyond the additional 365 days  SKILLED NURSING FACILITY CARE* 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  All approved amounts  All approved amounts  50  \$0  Up to \$141.50 a day  IUp to \$141.50 a day  All costs  All costs  All out \$141.50 a day  Through 100 <sup>th</sup> day  All costs  All but \$141.50 a day  Through 100 <sup>th</sup> day  All costs  All but \$141.50 a day  All costs  All costs  All costs  All costs  All costs  Medicare copayment/coinsurance for out-patient drugs and	- Additional 365 days	\$0	100% of Medicare eligible	\$0**
SKILLED NURSING FACILITY CARE* 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 - 21st through 100th day - 101st day and after  BLOOD - First 3 pints - Additional amounts  \$0  All but \$141.50 a day  \$0  Up to \$141.50 a day  All costs  BLOOD - First 3 pints - Additional amounts  \$0  All but very limited copayment/coinsurance for out-patient drugs and  Medicare  Copayment/coinsurance  for out-patient drugs and			expenses	
SKILLED NURSING FACILITY CARE* 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  All approved amounts  \$0 \$0 \$0  Up to \$141.50 a day  All costs  BLOOD - First 3 pints - Additional amounts  \$0 \$0 \$0  All costs  ### Additional amounts  ### All but very limited copayment/coinsurance doctor's certification of  ### Medicare  ### Copayment/coinsurance  ### Medicare  ### Medicare  ### Medicare  ### Medicare  ### Copayment/coinsurance  ### Medicare  ### Medicar	- Beyond the additional	\$0	\$0	All costs
FACILITY CARE* 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  BLOOD - First 3 pints - Additional amounts  \$0  \$0  All costs  All but \$141.50 a day  \$0  All costs  BLOOD - First 3 pints - Additional amounts  \$0  \$0  Medicare copayment/coinsurance doctor's certification of  ### Medicare copayment/coinsurance for out-patient drugs and  ### Medicare copayment/coinsurance for out-patient drugs and	365 days			
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  All approved amounts  \$0 \$0 \$0  -21 <sup>st</sup> through 100 <sup>th</sup> day  All but \$141.50 a day  \$0 Up to \$141.50 a day  -101 <sup>st</sup> day and after  \$0 \$0 All costs  BLOOD  - First 3 pints  - Additional amounts  HOSPICE CARE  You must meet Medicare's requirements, including a doctor's certification of  All but very limited copayment/coinsurance for out-patient drugs and	SKILLED NURSING			
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  All approved amounts  \$0\$  Up to \$141.50 a day  101st day and after  \$0\$  BLOOD  - First 3 pints  - Additional amounts  100%  HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of  All but very limited copayment/coinsurance for out-patient drugs and	FACILITY CARE*			
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  All but \$141.50 a day  50  Up to \$141.50 a day  Up to \$141.50 a day  101 <sup>st</sup> day and after  80  80  All costs  BLOOD  - First 3 pints  - Additional amounts  100%  HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of  All but very limited copayment/coinsurance for out-patient drugs and	You must meet Medicare's			
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  All but \$141.50 a day  50  Up to \$141.50 a day  Up to \$141.50 a day  All costs  BLOOD  - First 3 pints  - Additional amounts  100%  HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of  All but very limited copayment/coinsurance for out-patient drugs and  Medicare copayment/coinsurance  for out-patient drugs 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  All but \$141.50 a day  S0  Up to \$141.50 a day  Up to \$141.50 a day  All costs  BLOOD  - First 3 pints  - Additional amounts  NO  HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of  All but very limited copayment/coinsurance for out-patient drugs and  Medicare copayment/coinsurance  S0  Medicare copayment/coinsurance  S0  Medicare copayment/coinsurance  S0  Wedicare copayment/coinsurance				
facility. Within 30 days after leaving the hospital: - First 20 days All approved amounts 50  - 21 <sup>st</sup> through 100 <sup>th</sup> day All but \$141.50 a day  - 101 <sup>st</sup> day and after  S0  S0  All costs  BLOOD - First 3 pints - Additional amounts 100%  HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of  All but very limited copayment/coinsurance for out-patient drugs and  Medicare copayment/coinsurance for out-patient drugs and				
Within 30 days after leaving the hospital:  - First 20 days  All approved amounts  \$0 \$0 \$0  - 21 <sup>st</sup> through 100 <sup>th</sup> day  All but \$141.50 a day  \$0 Up to \$141.50 a day  - 101 <sup>st</sup> day and after  \$0 \$0 All costs  BLOOD  - First 3 pints  - Additional amounts  100%  \$0 \$0 \$0  Wedicare copayment/coinsurance for out-patient drugs and  \$0 \$0 \$0  Wedicare copayment/coinsurance for out-patient drugs and				
the hospital: - First 20 days  All approved amounts  \$0 \$0 \$0  - 21 <sup>st</sup> through 100 <sup>th</sup> day  All but \$141.50 a day  \$0 Up to \$141.50 a day  - 101 <sup>st</sup> day and after  \$0 \$0 All costs  BLOOD - First 3 pints - Additional amounts  100%  \$0 \$0 \$0  All costs  ### OF The Care You must meet Medicare's requirements, including a doctor's certification of  ### OF The Care Including a doctor's certification of  ### OF The Care Including a doctor's certification of  ### OF The Care Including a copayment/coinsurance for out-patient drugs and  ### OF The Care Including a copayment/coinsurance for out-patient drugs and  ### OF The Care Including a copayment/coinsurance for out-patient drugs and  ### OF The Care Including a copayment/coinsurance for out-patient drugs and  ### OF The Care Including a copayment/coinsurance for out-patient drugs and  ### OF The Care Including a copayment/coinsurance for out-patient drugs and  ### OF The Care Including a copayment/coinsurance for out-patient drugs and  ### OF The Care Including a copayment/coinsurance for out-patient drugs and  ### OF The Care Including a copayment/coinsurance for out-patient drugs and  ### OF The Care Including a copayment/coinsurance for out-patient drugs and  ### OF The Care Including a copayment/coinsurance for out-patient drugs and  ### OF The Care Including a copayment/coinsurance for out-patient drugs and  ### OF The Care Including a copayment/coinsurance for out-patient drugs and  ### OF The Care Including a copayment/coinsurance for out-patient drugs and  ### OF The Care Including a copayment/coinsurance for out-patient drugs and  ### OF The Care Including a copayment/coinsurance for out-patient drugs and  ### OF The Care Including a copayment/coinsurance for out-patient drugs and  ### OF The Care Including a copayment/coinsurance for out-patient drugs and  ### OF The Care Including a copayment/coinsurance for out-patient drugs and  ### OF The Care Including a copayment/coinsurance for out-patient drugs and including a copayment/coinsurance for out-patient	1			
- First 20 days  All approved amounts  \$0 \$0 \$0  - 21 <sup>st</sup> through 100 <sup>th</sup> day  All but \$141.50 a day  \$0 Up to \$141.50 a day  All costs  BLOOD  - First 3 pints  - Additional amounts  100%  \$0 \$0 \$0  S0 \$0  Whospice Care You must meet Medicare's requirements, including a doctor's certification of  All approved amounts  \$0 \$0 Up to \$141.50 a day  All costs  \$0 \$0 \$0  S0 \$0  \$0 \$0  Medicare copayment/coinsurance for out-patient drugs and				
- 21 <sup>st</sup> through 100 <sup>th</sup> day  All but \$141.50 a day  \$0  Up to \$141.50 a day  All costs  BLOOD  First 3 pints Additional amounts  HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of  All but \$141.50 a day  \$0  All costs  \$0  \$0  Medicare copayment/coinsurance for out-patient drugs and  \$0  Up to \$141.50 a day  All costs  \$0  \$0  \$0  \$0  \$0  \$0  \$0  \$0  \$0  \$			40	40
- 101st day and after \$0 \$0 All costs  BLOOD  - First 3 pints \$0 3 pints \$0  - Additional amounts 100% \$0 \$0  HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of for out-patient drugs and	- First 20 days	All approved amounts	\$0	\$0
BLOOD - First 3 pints \$0 3 pints \$0 - Additional amounts 100% \$0 \$0  HOSPICE CARE You must meet Medicare's requirements, including a copayment/coinsurance doctor's certification of for out-patient drugs and \$0    Medicare copayment/coinsurance copayment/coinsurance for out-patient drugs and   Copayment/coinsurance copayment/coin	- 21 <sup>st</sup> through 100 <sup>th</sup> day	All but \$141.50 a day	\$0	Up to \$141.50 a day
- First 3 pints \$0 3 pints \$0 - Additional amounts 100% \$0 \$0  HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of for out-patient drugs and \$0  \$0 \$0  Medicare copayment/coinsurance copayment/coinsurance copayment/coinsurance	- 101st day and after	\$0	\$0	All costs
- Additional amounts 100% \$0 \$0  HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of for out-patient drugs and for out-patient drugs and \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0	BLOOD			
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of for out-patient drugs and solutions.  Medicare solutions (copayment/coinsurance copayment/coinsurance)  solution (including a copayment/coinsurance)  for out-patient drugs and solutions.	- First 3 pints	\$0	3 pints	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of for out-patient drugs and solutions.  Medicare solutions (copayment/coinsurance copayment/coinsurance)  solution (including a copayment/coinsurance)  for out-patient drugs and solutions.	- Additional amounts	100%	\$0	\$0
You must meet Medicare's requirements, including a doctor's certification of doctor's certificat	HOSPICE CARE			
requirements, including a copayment/coinsurance copayment/coinsurance doctor's certification of for out-patient drugs and		All but very limited	Medicare	\$0
doctor's certification of for out-patient drugs and	requirements, including a			
	doctor's certification of			
terminal illness. inpatient respite care	terminal illness.			

\*\*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.

SERVICES	MEDICARE	PLAN PAYS	YOU PAY
	PAYS		
MEDICAL EXPENSES - IN OR OUT OF			
THE HOSPITAL AND OUTPATIENT			
HOSPITAL TREATMENT, 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	\$0	\$0	\$162 (Part B deductible)
Amounts*	ΨΟ	ΨΟ	\$102 (1 art B deductible)
Timounts			
- Remainder of Medical Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges			
(Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD			
- First 3 pints	\$0	All costs	\$0
N. (0160 CM III A 1	¢0	φo	\$162 (D. (D. 1.1. (31.1.)
- Next \$162 of Medicare Approved Amounts*	\$0	\$0	\$162 (Part B deductible)
Amounts**			
- Remainder of Medicare Approved	80%	20%	\$0
Amounts			, -
CLINICAL LABORATORY SERVICES			
-TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

#### PARTS A and B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTHCARE MEDICARE APPROVED SERVICES	IAIS		
<ul> <li>Medically necessary skilled care services and medical supplies</li> </ul>	100%	\$0	\$0
<ul> <li>Durable medical equipment</li> <li>First \$162 of Medicare Approved Amounts*</li> </ul>	\$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.

GEDVICEG	MEDICADE DAVIG	DI AN DAYO	VOLDAY
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board,			
general nursing and			
miscellaneous services and			
supplies:			
- First 60 days	All but \$1,132	\$1,132 (Part A deductible)	\$0
- 61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$283 a day	\$283 a day	\$0
- 91 <sup>st</sup> day and after:			
While using 60 lifetime	All but \$566 a day	\$566 a day	\$0
reserve days			
Once lifetime reserve days			
are used:			
- Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
- Beyond the additional 365	\$0	\$0	All costs
days			
SKILLED NURSING			
FACILITY CARE*			
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	All approved amounts	\$0	\$0
-21 <sup>st</sup> through 100 <sup>th</sup> day	All but \$141.50 a day	\$0	Up to \$141.50 a day
	•		
-101 <sup>st</sup> day and after	\$0	\$0	All costs
BLOOD			
-First 3 pints	\$0	3 pints	\$0
-Additional amounts	100%	\$0	\$0
HOSPICE CARE	All but very limited	Medicare copayment/coinsurance	\$0
Available as long as your	copayment/coinsurance for	, ,	
doctor certifies you are	outpatient drugs and		
terminally ill and you elect to	inpatient respite care		
receive these services			

<sup>\*\*</sup>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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN			
OR OUT OF THE HOSPITAL			
AND OUT-PATIENT			
HOSPITAL TREATMENT, 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	4.5		
Approved Amounts*	\$0	\$0	\$162 (Part B deductible)
Daniel I. a. CM. Para	C 11 200/	C 11 200/	Φ0
Remainder of Medicare	Generally 80%	Generally 20%	\$0
Approved Amounts			
Part B Excess Charges	\$0	\$0	All costs
(Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD			
- First 3 pints	\$0	All costs	\$0
That 5 pines	ΨΟ	7 HI COSES	Ψ
- Next \$162 of Medicare	\$0	\$0	\$162 (Part B deductible)
Approved Amounts*		Ψ 0	φ10 <b>2</b> (1 a20 2 acastracto)
- Remainder of Medicare	80%	20%	\$0
Approved Amounts			
CLINICAL LABORATORY			
SERVICES—TESTS FOR			
DIAGNOSTIC SERVICES	100%	\$0	\$0

#### PARTS A AND B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTHCARE			
MEDICARE APPROVED			
SERVICES			
-Medically necessary skilled care	100%	\$0	\$0
services and medical supplies			
- 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 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
HOSPITALIZATION*			
Semiprivate room and board,			
general nursing and			
miscellaneous services and			
supplies			
- First 60 days	All but \$1,132	\$1,132 (Part A deductible)	\$0
- 61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$283 a day	\$283 a day	\$0
- 91 <sup>st</sup> day and after:	·		
While using 60 lifetime reserve days	All but \$566 a day	\$566 a day	\$0
Once lifetime reserve			
days are used:	\$0	1000/ - CM - 1' 1' - '1-1	\$0**
- Additional 365 days	\$0	100% of Medicare eligible expenses	T ~
- Beyond the additional	\$0	\$0	All costs
365 days SKILLED NURSING			
FACILITY CARE*			
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			
days after leaving the hospital			
- First 20 days	All approved amounts	\$0	\$0
- 21 <sup>st</sup> through 100 <sup>th</sup> day	All but \$141.50 a day	Up to \$141.50 a day	\$0
- 101 <sup>st</sup> day and after	\$0	\$0	All costs
BLOOD			
- First 3 pints	\$0	3 pints	\$0
- Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's	All but very limited	Medicare copayment/coinsurance	Balance
requirements, including a	copayment/coinsurance		
doctor's certification of	for out-patient drugs and		
terminal illness.	inpatient respite care		

\*\*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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—			
IN OR OUT OF THE HOSPITAL			
AND OUTPATIENT HOSPITAL			
<b>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	\$0	\$162 (Part B deductible)	\$0
Amounts*			
- Remainder of Medicare Approved	Generally 80%	Generally 20%	\$0
Amounts			
Part B Excess Charges			
(Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD			
- First 3 pints	\$0	All costs	\$0
- Next \$162 of Medicare Approved	\$0	\$162 (Part B deductible)	\$0
Amounts*			
- Remainder of Medicare Approved	80%	20%	\$0
Amounts			
CLINICAL LABORATORY			
SERVICES—TESTS FOR DIAGNOSTIC	100%	\$0	\$0
SERVICES			

#### PARTS A AND B

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

## GEISINGER GOLD MEDICARE SUPPLEMENT PLAN C

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED			
BY MEDICARE			
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	20% and
		benefit of \$50,000	amounts
			over the
			\$50,000
			lifetime
			maximum

#### 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
HOSPITALIZATION*			
Semiprivate room and board,			
general nursing and			
miscellaneous services and			
supplies			
- First 60 days	All but \$1,132	\$1,132 (Part A deductible)	\$0
- 61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$283 a day	\$283 a day	\$0
- 91 <sup>st</sup> day and after:			
While using 60 lifetime	All but \$566 a day	\$566 a day	\$0
reserve days			
Once lifetime reserve			
days are used:			
- Additional 365 days	\$0	100% of Medicare eligible	\$0**
	4.0	expenses	
- Beyond the additional	\$0	\$0	All costs
365 days			
SKILLED NURSING			
FACILITY CARE*			
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:			40
- First 20 days	All approved amounts	\$0	\$0
- 21 <sup>st</sup> through 100 <sup>th</sup> day	All but \$141.50 a day	Up to \$141.50 a day	\$0
21 through 100 day	7111 οαι φ1+1.50 α ααγ	ορ το φ1+1.50 α ααγ	Ψ
- 101 <sup>st</sup> day and after	\$0	\$0	All costs
BLOOD			
- First 3 pints	\$0	3 pints	\$0
- Additional amounts	100%	\$Ô	\$0
HOSPICE CARE			
You must meet Medicare's	All but very limited	Medicare copayment/coinsurance	\$0
requirements, including a	copayment/coinsurance		
doctor's certification of	for outpatient drugs		
terminal illness.	and inpatient respite		
	care		

<sup>\*\*</sup>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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN	WIEDICHKE THIS		1001111
OR OUT OF THE			
HOSPITAL AND			
OUTPATIENT HOSPITAL			
TREATMENT, such as			
physician's services, inpatient			
and outpatient medical and			
surgical services and supplies,			
physical and speech therapy,			
diagnostic tests, durable			
medical equipment:	4.0		4.0
- First \$162 of Medicare	\$0	\$162 (Part B deductible)	\$0
Approved Amounts*			
- Remainder of Medicare	Generally 80%	Generally 20%	\$0
Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges			
(Above Medicare Approved	\$0	100%	\$0
Amounts)	Ψ	10070	ΨΟ
BLOOD			
- First 3 pints	\$0	All costs	\$0
1			
- Next \$162 of Medicare	\$0	\$162 (Part B deductible)	\$0
Approved Amounts*			
- Remainder of Medicare	80%	20%	\$0
Approved Amounts			
CLINICAL LABORATORY			
SERVICES—TESTS FOR	1000/	40	Φ0
DIAGNOSTIC SERVICES	100%	\$0	\$0

## GEISINGER GOLD MEDICARE SUPPLEMENT PLAN F

## PARTS A AND B

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

FOREIGN TRAVEL - NOT COVERED BY MEDICARE 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.

HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies - First 60 days - 61st through 90th day - 91st day and after: While using 60 lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days - Beyond the additional 365 days  SKILLED NURSING FACILITY CARE* 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	SERVICES	MEDICARE PAYS	(AFTER YOU PAY \$2,000	(IN ADDITION TO \$2,000
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies - First 60 days - 61st through 90th day - 91st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days - Beyond the additional 365 days  SKILLED NURSING FACILITY CARE* 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				
Semiprivate room and board, general nursing and miscellaneous services and supplies  - First 60 days  - 61st through 90th day - 91st day and after:  While using 60 lifetime reserve days Once lifetime reserve days are used:  - Additional 365 days  - Beyond the additional 365 days  SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days after leaving  Mall but \$1,132  \$1,132 (Part A deductible) \$0  \$283 a day \$0  \$100% of Medicare eligible expenses  \$0  All costs  All but \$566 a day \$0  \$0  All costs				* *
general nursing and miscellaneous services and supplies  - First 60 days  - 61st through 90th day  - 91st day and after:  - While using 60 lifetime reserve days  - Once lifetime reserve days  - Additional 365 days  - Beyond the additional 365 days  SKILLED NURSING FACILITY CARE* 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	HOSPITALIZATION*			
miscellaneous services and supplies - First 60 days - 61st through 90th day - 91st day and after: While using 60 lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days  SKILLED NURSING FACILITY CARE* 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	Semiprivate room and board,			
supplies - First 60 days - 61st through 90th day - 91st day and after: While using 60 lifetime reserve days Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days  SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days after leaving within 30 days after leaving  All but \$1,132 \$1,132 (Part A deductible) \$0 \$283 a day \$0 \$100% of Medicare eligible expenses  100% of Medicare eligible expenses  80 All costs  All costs	general nursing and			
- First 60 days - 61st through 90th day - 91st day and after: While using 60 lifetime reserve days Once lifetime reserve days are used: - Additional 365 days Beyond the additional 365 days  SKILLED NURSING FACILITY CARE* 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  All but \$1,132 \$1,132 (Part A deductible) \$0 \$283 a day \$0 \$100% of Medicare eligible expenses  100% of Medicare eligible expenses  80 All costs	miscellaneous services and			
- 61st through 90th day - 91st day and after: While using 60 lifetime reserve days Once lifetime reserve days are used: - Additional 365 days Beyond the additional 365 days  SKILLED NURSING FACILITY CARE* 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  All but \$283 a day \$283 a day \$0 \$0 \$0 \$0 \$100% of Medicare eligible expenses  \$0 \$All costs  All costs  All costs  **All but \$566 a day \$0 ***  **All but \$566 a day  **O ** **All but \$566 a day  **O ** **All but \$566 a day  **O ** ** **All but \$566 a day  **O ** ** **All but \$566 a day  ** ** **O ** ** ** **All but \$566 a day  ** ** ** ** ** ** ** ** ** ** ** ** *	supplies			
- 91st day and after: While using 60 lifetime reserve days Once lifetime reserve days are used: - Additional 365 days Beyond the additional 365 days  SKILLED NURSING FACILITY CARE* 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  All but \$566 a day  \$0  100% of Medicare eligible expenses  \$0  All costs  \$0  All costs		All but \$1,132	\$1,132 (Part A deductible)	\$0
While using 60 lifetime reserve days Once lifetime reserve days are used: - Additional 365 days  - Beyond the additional 365 days  SKILLED NURSING FACILITY CARE* 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  All but \$566 a day  \$0  100% of Medicare eligible expenses  \$0 ***  All costs  \$0  All costs  ### Costs  #	- 61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$283 a day	\$283 a day	\$0
reserve days Once lifetime reserve days are used: - Additional 365 days  - Beyond the additional 365 days  SKILLED NURSING FACILITY CARE* 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    SAME	- 91 <sup>st</sup> day and after:			
Once lifetime reserve days are used: - Additional 365 days  - Beyond the additional 365 days  SKILLED NURSING FACILITY CARE* 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  SKILLED NURSING FACILITY CARE*  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	While using 60 lifetime	All but \$566 a day	\$566 a day	\$0
days are used: - Additional 365 days  - Beyond the additional 365 days  SKILLED NURSING FACILITY CARE* 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  \$0				
- Additional 365 days  - Beyond the additional 365 days  SKILLED NURSING FACILITY CARE* 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  \$0 \$100% of Medicare eligible expenses  All costs  All costs	Once lifetime reserve			
- Beyond the additional 365 days  SKILLED NURSING FACILITY CARE* 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				
- Beyond the additional 365 days  SKILLED NURSING FACILITY CARE* 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	- Additional 365 days	\$0	100% of Medicare eligible	\$0***
365 days  SKILLED NURSING FACILITY CARE* 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				
SKILLED NURSING FACILITY CARE* 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	,	\$0	\$0	All costs
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				
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				
requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving				
having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving				
at least 3 days and entered a Medicare-approved facility within 30 days after leaving	1			
Medicare-approved facility within 30 days after leaving				
within 30 days after leaving	•			
	* *			
	•			
the hospital:	_			
- First 20 days All approved amounts \$0 \$0	- First 20 days	All approved amounts	\$0	\$0
21St 1 1 100th 1	oust it is a sooth it	A 11 1	XX	40
- 21 <sup>st</sup> through 100 <sup>th</sup> day  All but \$141.50 a day  Up to \$141.50 a day  \$0	- 21° through 100° day	All but \$141.50 a day	Up to \$141.50 a day	\$0
- 101 <sup>st</sup> day and after \$0 \$0 All costs	- 101 <sup>st</sup> day and after	\$0	\$0	All costs
BLOOD	·			
- First 3 pints \$0 3 pints \$0		\$0	3 pints	\$0
- Additional amounts 100% \$0 \$0	*			
HOSPICE CARE				
You must meet Medicare's All but very limited Medicare \$0	You must meet Medicare's	All but very limited	Medicare	\$0
requirements, including a copayment/coinsurance for copayment/coinsurance	requirements, including a		copayment/coinsurance	
doctor's certification of outpatient drugs and			-	
terminal illness. inpatient respite care				

<sup>\*\*\*</sup> 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

<sup>\*\*</sup>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.

	YOU PAY
2 (Part B deductible)	\$0
nerally 20%	\$0
9%	\$0
costs	\$0
2 (Part B deductible)	\$0
6	\$0
	\$0
ne 19%	erally 20%

<sup>\*</sup>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.

## GEISINGER GOLD MEDICARE SUPPLEMENT HIGH DEDUCTIBLE PLAN F

#### PARTS A AND B

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

SERVICES	MEDICARE PAYS	(AFTER YOU PAY \$2,000 DEDUCTIBLE,**) PLAN PAYS	(IN ADDITION TO \$2,000 DEDUCTIBLE,**) YOU PAY
FOREIGN TRAVEL—NOT			
COVERED BY MEDICARE			
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*
HOSPITALIZATION*			
Semiprivate room and board,			
general nursing and miscellaneous			
services and supplies:			
- First 60 days	All but \$1,132	\$566 (50% of Part A	\$566 (50% of Part A
·		deductible)	deductible)
- 61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$283 a day	\$283 a day	\$0
	-	-	
- 91 <sup>st</sup> day and after:			
While using 60 lifetime	All but \$566 a day	\$566 a day	\$0
reserve days			
Once lifetime reserve days are			
used:			
- Additional 365 days	\$0	100% of Medicare	\$0**
		eligible expenses	
- Beyond the additional 365	\$0	\$0	All costs
days			
SKILLED NURSING			
FACILITY CARE*			
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	All approved amounts	\$0	\$0
- 21 <sup>st</sup> through 100 <sup>th</sup> day	All but \$141.50 a day	Up to \$141.50 a day	\$0
- 101 <sup>st</sup> day and after	\$0	\$0	All costs
BLOOD			
- First 3 pints	\$0	3 pints	\$0
- Additional amounts	100%	\$0	\$0
HOSPICE CARE	All but very limited	3.5 11	40
You must meet Medicare's	co-payment/	Medicare	\$0
requirements, including a	coinsurance for	copayment/coinsurance	
doctor's certification of terminal	outpatient drugs and		
illness	inpatient respite care		

<sup>\*\*</sup>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.

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

## PARTS A AND B

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

## GEISINGER GOLD MEDICARE SUPPLEMENT PLAN M

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE 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*
HOSPITALIZATION*			
Semiprivate room and board,			
general nursing and miscellaneous			
services and supplies:			
- First 60 days	All but \$1,132	\$1,132 (Part A deductible)	\$0
oct th -		4.5.5.	
- 61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$283 a day	\$283 a day	\$0
- 91 <sup>st</sup> day and after:			
- 91 day and after While using 60 lifetime	All but \$566 a day	\$566 a day	\$0
reserve days	All but \$300 a day	\$300 a day	φυ
Once lifetime reserve days are			
used:			
- Additional 365 days	\$0	100% of Medicare eligible	\$0**
Traditional 202 days	40	expenses	Ψ0
- Beyond the additional 365	\$0	\$0	All costs
days	7.7		
SKILLED NURSING			
FACILITY CARE*			
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	All approved amounts	\$0	\$0
- 21 <sup>st</sup> through 100 <sup>th</sup> day	All but \$141.50 a day	Up to \$141.50 a day	\$0
- 101 <sup>st</sup> day and after	\$0	\$0	All costs
BLOOD	Φ0		Φ0
- First 3 pints	\$0	3 pints	\$0
- Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's	All but very limited	Medicare	\$0
requirements, including a	co-payment/ coinsurance for		φυ
doctor's certification of terminal	outpatient drugs and	copayment/coinsurance	
illness	inpatient respite care		
inicss	impatient respite care		

<sup>\*\*</sup> 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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, 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 Medicare Approved Amounts	Generally 80%	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.	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.
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD - 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
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

## GEISINGER GOLD MEDICARE SUPPLEMENT PLAN N

## PARTS A AND B

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

#### PLAN M

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE			
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