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	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	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	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deducible	Part A Deducible	Part A Deducible	Part A Deductible	Part A Deducible	50% Part A Deducible	75% Part A Deducible	50% Part A Deducible	Part A Deducible
		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 $5240; paid at 100% after limit reached***	Out-of-pocket limit $2620; 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 $2240 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2240. 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.

Area 1

(Allegheny, Armstrong, Beaver, Butler, Fayette, Washington and Westmoreland Counties)
Rates are effective January 1, 2018, and are subject to change

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	$ 120.54	$ 118.66	$ 144.22	$ 141.97	$ 216.64	$ 213.27	$ 283.02	$ 278.62	$ 50.64	$ 49.85	$ 147.97	$ 145.67	$ 168.60	$ 165.98
65	$ 120.54	$ 118.66	$ 144.22	$ 141.97	$ 216.64	$ 213.27	$ 283.02	$ 278.62	$ 50.64	$ 49.85	$ 147.97	$ 145.67	$ 168.60	$ 165.98
66	$ 127.51	$ 125.53	$ 152.56	$ 150.19	$ 229.17	$ 225.61	$ 299.40	$ 294.75	$ 53.57	$ 52.74	$ 156.53	$ 154.10	$ 178.36	$ 175.59
67	$ 134.35	$ 132.26	$ 160.74	$ 158.24	$ 241.45	$ 237.70	$ 315.45	$ 310.54	$ 56.44	$ 55.56	$ 164.92	$ 162.36	$ 187.92	$ 185.00
68	$ 141.05	$ 138.86	$ 168.76	$ 166.14	$ 253.50	$ 249.56	$ 331.19	$ 326.04	$ 59.26	$ 58.33	$ 173.15	$ 170.46	$ 197.30	$ 194.23
69	$ 147.65	$ 145.35	$ 176.65	$ 173.90	$ 265.36	$ 261.23	$ 346.67	$ 341.28	$ 62.03	$ 61.06	$ 181.25	$ 178.43	$ 206.52	$ 203.31
70	$ 154.15	$ 151.75	$ 184.43	$ 181.56	$ 277.05	$ 272.74	$ 361.94	$ 356.31	$ 64.76	$ 63.75	$ 189.23	$ 186.29	$ 215.62	$ 212.27
71	$ 160.59	$ 158.09	$ 192.13	$ 189.15	$ 288.61	$ 284.13	$ 377.06	$ 371.19	$ 67.46	$ 66.41	$ 197.13	$ 194.07	$ 224.62	$ 221.13
72	$ 166.98	$ 164.39	$ 199.78	$ 196.68	$ 300.11	$ 295.44	$ 392.07	$ 385.97	$ 70.15	$ 69.06	$ 204.98	$ 201.80	$ 233.57	$ 229.94
73	$ 173.36	$ 170.67	$ 207.42	$ 204.19	$ 311.57	$ 306.73	$ 407.05	$ 400.72	$ 72.83	$ 71.70	$ 212.82	$ 209.51	$ 242.49	$ 238.72
74	$ 179.76	$ 176.96	$ 215.07	$ 211.73	$ 323.07	$ 318.05	$ 422.07	$ 415.51	$ 75.52	$ 74.34	$ 220.67	$ 217.24	$ 251.44	$ 247.53
75	$ 186.21	$ 183.31	$ 222.79	$ 219.32	$ 334.66	$ 329.46	$ 437.21	$ 430.41	$ 78.23	$ 77.01	$ 228.59	$ 225.03	$ 260.46	$ 256.41
76	$ 192.75	$ 189.75	$ 230.61	$ 227.03	$ 346.42	$ 341.03	$ 452.57	$ 445.53	$ 80.97	$ 79.71	$ 236.61	$ 232.94	$ 269.61	$ 265.42
77	$ 199.43	$ 196.33	$ 238.60	$ 234.89	$ 358.42	$ 352.84	$ 468.25	$ 460.97	$ 83.78	$ 82.48	$ 244.81	$ 241.00	$ 278.95	$ 274.61
78	$ 206.29	$ 203.08	$ 246.81	$ 242.98	$ 370.75	$ 364.99	$ 484.37	$ 476.83	$ 86.66	$ 85.31	$ 253.24	$ 249.30	$ 288.55	$ 284.06
79	$ 213.40	$ 210.08	$ 255.32	$ 251.35	$ 383.52	$ 377.56	$ 501.05	$ 493.26	$ 89.65	$ 88.25	$ 261.96	$ 257.89	$ 298.49	$ 293.85
80	$ 220.81	$ 217.37	$ 264.18	$ 260.08	$ 396.85	$ 390.67	$ 518.45	$ 510.39	$ 92.76	$ 91.32	$ 271.06	$ 266.84	$ 308.86	$ 304.06
81	$ 228.60	$ 225.04	$ 273.50	$ 269.25	$ 410.84	$ 404.46	$ 536.74	$ 528.40	$ 96.03	$ 94.54	$ 280.62	$ 276.26	$ 319.75	$ 314.78
82	$ 236.84	$ 233.16	$ 283.37	$ 278.96	$ 425.67	$ 419.05	$ 556.11	$ 547.46	$ 99.50	$ 97.95	$ 290.75	$ 286.22	$ 331.29	$ 326.14
83	$ 245.64	$ 241.82	$ 293.89	$ 289.32	$ 441.48	$ 434.61	$ 576.76	$ 567.79	$ 103.19	$ 101.59	$ 301.54	$ 296.85	$ 343.59	$ 338.25
84	$ 255.09	$ 251.12	$ 305.20	$ 300.45	$ 458.45	$ 451.33	$ 598.94	$ 589.63	$ 107.16	$ 105.49	$ 313.14	$ 308.27	$ 356.81	$ 351.26
85	$ 285.00	$ 280.57	$ 340.99	$ 335.68	$ 512.22	$ 504.25	$ 669.18	$ 658.77	$ 119.73	$ 117.87	$ 349.86	$ 344.42	$ 398.65	$ 392.45
86	$ 285.00	$ 280.57	$ 340.99	$ 335.68	$ 512.22	$ 504.25	$ 669.18	$ 658.77	$ 119.73	$ 117.87	$ 349.86	$ 344.42	$ 398.65	$ 392.45
87	$ 285.00	$ 280.57	$ 340.99	$ 335.68	$ 512.22	$ 504.25	$ 669.18	$ 658.77	$ 119.73	$ 117.87	$ 349.86	$ 344.42	$ 398.65	$ 392.45
88	$ 285.00	$ 280.57	$ 340.99	$ 335.68	$ 512.22	$ 504.25	$ 669.18	$ 658.77	$ 119.73	$ 117.87	$ 349.86	$ 344.42	$ 398.65	$ 392.45
89	$ 285.00	$ 280.57	$ 340.99	$ 335.68	$ 512.22	$ 504.25	$ 669.18	$ 658.77	$ 119.73	$ 117.87	$ 349.86	$ 344.42	$ 398.65	$ 392.45
90	$ 285.00	$ 280.57	$ 340.99	$ 335.68	$ 512.22	$ 504.25	$ 669.18	$ 658.77	$ 119.73	$ 117.87	$ 349.86	$ 344.42	$ 398.65	$ 392.45
91	$ 285.00	$ 280.57	$ 340.99	$ 335.68	$ 512.22	$ 504.25	$ 669.18	$ 658.77	$ 119.73	$ 117.87	$ 349.86	$ 344.42	$ 398.65	$ 392.45
92	$ 285.00	$ 280.57	$ 340.99	$ 335.68	$ 512.22	$ 504.25	$ 669.18	$ 658.77	$ 119.73	$ 117.87	$ 349.86	$ 344.42	$ 398.65	$ 392.45
93	$ 285.00	$ 280.57	$ 340.99	$ 335.68	$ 512.22	$ 504.25	$ 669.18	$ 658.77	$ 119.73	$ 117.87	$ 349.86	$ 344.42	$ 398.65	$ 392.45
94	$ 285.00	$ 280.57	$ 340.99	$ 335.68	$ 512.22	$ 504.25	$ 669.18	$ 658.77	$ 119.73	$ 117.87	$ 349.86	$ 344.42	$ 398.65	$ 392.45
95	$ 285.00	$ 280.57	$ 340.99	$ 335.68	$ 512.22	$ 504.25	$ 669.18	$ 658.77	$ 119.73	$ 117.87	$ 349.86	$ 344.42	$ 398.65	$ 392.45
96	$ 285.00	$ 280.57	$ 340.99	$ 335.68	$ 512.22	$ 504.25	$ 669.18	$ 658.77	$ 119.73	$ 117.87	$ 349.86	$ 344.42	$ 398.65	$ 392.45
97	$ 285.00	$ 280.57	$ 340.99	$ 335.68	$ 512.22	$ 504.25	$ 669.18	$ 658.77	$ 119.73	$ 117.87	$ 349.86	$ 344.42	$ 398.65	$ 392.45
98	$ 285.00	$ 280.57	$ 340.99	$ 335.68	$ 512.22	$ 504.25	$ 669.18	$ 658.77	$ 119.73	$ 117.87	$ 349.86	$ 344.42	$ 398.65	$ 392.45
99+	$ 285.00	$ 280.57	$ 340.99	$ 335.68	$ 512.22	$ 504.25	$ 669.18	$ 658.77	$ 119.73	$ 117.87	$ 349.86	$ 344.42	$ 398.65	$ 392.45

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

Apply a factor of 1.15 for Standard 1 Class rates

Area 2

(Bucks, Chester, Deleware, Montgomery and Philadelphia Counties)

Rates are effective January 1, 2018, and are subject to change

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	$ 129.80	$ 127.78	$ 149.42	$ 147.10	$ 221.42	$ 217.98	$ 289.33	$ 284.83	$ 51.77	$ 50.96	$ 153.90	$ 151.50	$ 171.90	$ 169.23
65	$ 129.80	$ 127.78	$ 149.42	$ 147.10	$ 221.42	$ 217.98	$ 289.33	$ 284.83	$ 51.77	$ 50.96	$ 153.90	$ 151.50	$ 171.90	$ 169.23
66	$ 137.32	$ 135.18	$ 158.07	$ 155.61	$ 234.23	$ 230.59	$ 306.08	$ 301.32	$ 54.77	$ 53.91	$ 162.80	$ 160.27	$ 181.85	$ 179.03
67	$ 144.67	$ 142.42	$ 166.54	$ 163.95	$ 246.79	$ 242.95	$ 322.48	$ 317.46	$ 57.70	$ 56.80	$ 171.53	$ 168.86	$ 191.60	$ 188.62
68	$ 151.89	$ 149.53	$ 174.85	$ 172.13	$ 259.10	$ 255.07	$ 338.57	$ 333.31	$ 60.58	$ 59.64	$ 180.09	$ 177.29	$ 201.16	$ 198.03
69	$ 158.99	$ 156.52	$ 183.02	$ 180.18	$ 271.21	$ 267.00	$ 354.40	$ 348.89	$ 63.41	$ 62.43	$ 188.51	$ 185.58	$ 210.57	$ 207.29
70	$ 166.00	$ 163.42	$ 191.09	$ 188.12	$ 283.16	$ 278.76	$ 370.01	$ 364.26	$ 66.21	$ 65.18	$ 196.81	$ 193.75	$ 219.84	$ 216.42
71	$ 172.93	$ 170.24	$ 199.07	$ 195.97	$ 294.99	$ 290.40	$ 385.46	$ 379.47	$ 68.97	$ 67.90	$ 205.03	$ 201.84	$ 229.02	$ 225.46
72	$ 179.82	$ 177.02	$ 206.99	$ 203.77	$ 306.73	$ 301.96	$ 400.81	$ 394.58	$ 71.72	$ 70.60	$ 213.19	$ 209.88	$ 238.14	$ 234.44
73	$ 186.69	$ 183.78	$ 214.90	$ 211.56	$ 318.45	$ 313.50	$ 416.12	$ 409.65	$ 74.46	$ 73.30	$ 221.34	$ 217.90	$ 247.24	$ 243.39
74	$ 193.58	$ 190.57	$ 222.83	$ 219.37	$ 330.20	$ 325.07	$ 431.48	$ 424.77	$ 77.20	$ 76.00	$ 229.51	$ 225.94	$ 256.36	$ 252.38
75	$ 200.52	$ 197.40	$ 230.83	$ 227.24	$ 342.05	$ 336.73	$ 446.96	$ 440.01	$ 79.97	$ 78.73	$ 237.74	$ 234.04	$ 265.56	$ 261.43
76	$ 207.56	$ 204.34	$ 238.93	$ 235.22	$ 354.06	$ 348.56	$ 462.66	$ 455.47	$ 82.78	$ 81.50	$ 246.09	$ 242.27	$ 274.89	$ 270.61
77	$ 214.76	$ 211.42	$ 247.21	$ 243.37	$ 366.33	$ 360.63	$ 478.69	$ 471.24	$ 85.65	$ 84.32	$ 254.62	$ 250.66	$ 284.41	$ 279.99
78	$ 222.15	$ 218.69	$ 255.72	$ 251.74	$ 378.94	$ 373.05	$ 495.16	$ 487.46	$ 88.60	$ 87.22	$ 263.38	$ 259.29	$ 294.20	$ 289.63
79	$ 229.80	$ 226.23	$ 264.53	$ 260.42	$ 391.99	$ 385.90	$ 512.22	$ 504.26	$ 91.65	$ 90.23	$ 272.45	$ 268.22	$ 304.33	$ 299.60
80	$ 237.78	$ 234.08	$ 273.72	$ 269.46	$ 405.61	$ 399.30	$ 530.01	$ 521.77	$ 94.84	$ 93.36	$ 281.92	$ 277.53	$ 314.90	$ 310.01
81	$ 246.17	$ 242.34	$ 283.37	$ 278.97	$ 419.91	$ 413.39	$ 548.71	$ 540.18	$ 98.18	$ 96.65	$ 291.86	$ 287.32	$ 326.01	$ 320.94
82	$ 255.05	$ 251.08	$ 293.60	$ 289.03	$ 435.06	$ 428.30	$ 568.50	$ 559.66	$ 101.72	$ 100.14	$ 302.39	$ 297.69	$ 337.77	$ 332.52
83	$ 264.52	$ 260.41	$ 304.50	$ 299.76	$ 451.22	$ 444.20	$ 589.62	$ 580.45	$ 105.50	$ 103.86	$ 313.62	$ 308.74	$ 350.32	$ 344.87
84	$ 274.70	$ 270.42	$ 316.21	$ 311.29	$ 468.58	$ 461.29	$ 612.29	$ 602.77	$ 109.56	$ 107.85	$ 325.68	$ 320.62	$ 363.79	$ 358.14
85	$ 306.91	$ 302.14	$ 353.29	$ 347.80	$ 523.52	$ 515.38	$ 684.10	$ 673.46	$ 122.41	$ 120.50	$ 363.88	$ 358.22	$ 406.45	$ 400.13
86	$ 306.91	$ 302.14	$ 353.29	$ 347.80	$ 523.52	$ 515.38	$ 684.10	$ 673.46	$ 122.41	$ 120.50	$ 363.88	$ 358.22	$ 406.45	$ 400.13
87	$ 306.91	$ 302.14	$ 353.29	$ 347.80	$ 523.52	$ 515.38	$ 684.10	$ 673.46	$ 122.41	$ 120.50	$ 363.88	$ 358.22	$ 406.45	$ 400.13
88	$ 306.91	$ 302.14	$ 353.29	$ 347.80	$ 523.52	$ 515.38	$ 684.10	$ 673.46	$ 122.41	$ 120.50	$ 363.88	$ 358.22	$ 406.45	$ 400.13
89	$ 306.91	$ 302.14	$ 353.29	$ 347.80	$ 523.52	$ 515.38	$ 684.10	$ 673.46	$ 122.41	$ 120.50	$ 363.88	$ 358.22	$ 406.45	$ 400.13
90	$ 306.91	$ 302.14	$ 353.29	$ 347.80	$ 523.52	$ 515.38	$ 684.10	$ 673.46	$ 122.41	$ 120.50	$ 363.88	$ 358.22	$ 406.45	$ 400.13
91	$ 306.91	$ 302.14	$ 353.29	$ 347.80	$ 523.52	$ 515.38	$ 684.10	$ 673.46	$ 122.41	$ 120.50	$ 363.88	$ 358.22	$ 406.45	$ 400.13
92	$ 306.91	$ 302.14	$ 353.29	$ 347.80	$ 523.52	$ 515.38	$ 684.10	$ 673.46	$ 122.41	$ 120.50	$ 363.88	$ 358.22	$ 406.45	$ 400.13
93	$ 306.91	$ 302.14	$ 353.29	$ 347.80	$ 523.52	$ 515.38	$ 684.10	$ 673.46	$ 122.41	$ 120.50	$ 363.88	$ 358.22	$ 406.45	$ 400.13
94	$ 306.91	$ 302.14	$ 353.29	$ 347.80	$ 523.52	$ 515.38	$ 684.10	$ 673.46	$ 122.41	$ 120.50	$ 363.88	$ 358.22	$ 406.45	$ 400.13
95	$ 306.91	$ 302.14	$ 353.29	$ 347.80	$ 523.52	$ 515.38	$ 684.10	$ 673.46	$ 122.41	$ 120.50	$ 363.88	$ 358.22	$ 406.45	$ 400.13
96	$ 306.91	$ 302.14	$ 353.29	$ 347.80	$ 523.52	$ 515.38	$ 684.10	$ 673.46	$ 122.41	$ 120.50	$ 363.88	$ 358.22	$ 406.45	$ 400.13
97	$ 306.91	$ 302.14	$ 353.29	$ 347.80	$ 523.52	$ 515.38	$ 684.10	$ 673.46	$ 122.41	$ 120.50	$ 363.88	$ 358.22	$ 406.45	$ 400.13
98	$ 306.91	$ 302.14	$ 353.29	$ 347.80	$ 523.52	$ 515.38	$ 684.10	$ 673.46	$ 122.41	$ 120.50	$ 363.88	$ 358.22	$ 406.45	$ 400.13
99+	$ 306.91	$ 302.14	$ 353.29	$ 347.80	$ 523.52	$ 515.38	$ 684.10	$ 673.46	$ 122.41	$ 120.50	$ 363.88	$ 358.22	$ 406.45	$ 400.13

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

Apply a factor of 1.15 for Standard 1 Class rates

Area 3

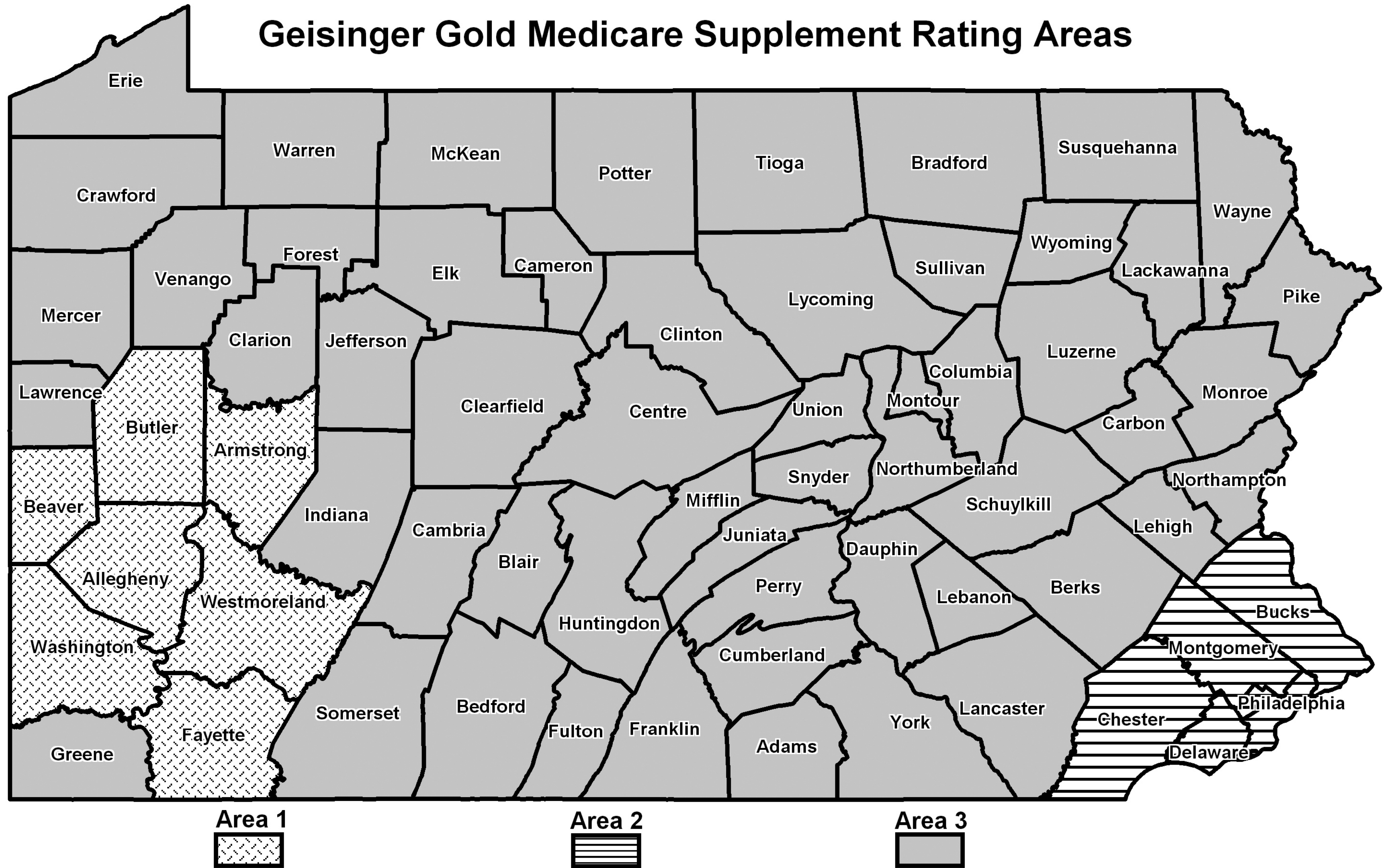
(Adams, Bedford, Berks, Blair, Bradford, Cambria, Cameron, Carbon, Centre, Clarion, Clearfield, Clinton, Columbia, Crawford, Cumberland, Dauphin, Elk, Erie, Forest, Franklin, Fulton, Greene, Huntingdon, Indiana, Jefferson, Juniata, Lackawanna, Lancaster, Lawrence, Lebanon, Lehigh, Luzerne, Lycoming,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

Rates are effective January 1, 2018, and are subject to change

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	$ 110.58	$ 108.86	$ 127.97	$ 125.98	$ 192.89	$ 189.89	$ 251.99	$ 248.08	$ 46.07	$ 45.36	$ 132.43	$ 130.37	$ 148.87	$ 146.56
65	$ 110.58	$ 108.86	$ 127.97	$ 125.98	$ 192.89	$ 189.89	$ 251.99	$ 248.08	$ 46.07	$ 45.36	$ 132.43	$ 130.37	$ 148.87	$ 146.56
66	$ 116.98	$ 115.16	$ 135.37	$ 133.27	$ 204.05	$ 200.88	$ 266.58	$ 262.43	$ 48.74	$ 47.98	$ 140.10	$ 137.92	$ 157.49	$ 155.04
67	$ 123.25	$ 121.33	$ 142.63	$ 140.41	$ 214.98	$ 211.64	$ 280.86	$ 276.50	$ 51.35	$ 50.55	$ 147.60	$ 145.31	$ 165.93	$ 163.35
68	$ 129.40	$ 127.39	$ 149.75	$ 147.42	$ 225.71	$ 222.20	$ 294.88	$ 290.30	$ 53.92	$ 53.08	$ 154.97	$ 152.56	$ 174.21	$ 171.50
69	$ 135.45	$ 133.34	$ 156.75	$ 154.31	$ 236.26	$ 232.59	$ 308.67	$ 303.87	$ 56.44	$ 55.56	$ 162.22	$ 159.69	$ 182.35	$ 179.52
70	$ 141.42	$ 139.22	$ 163.65	$ 161.11	$ 246.67	$ 242.84	$ 322.26	$ 317.25	$ 58.92	$ 58.01	$ 169.36	$ 166.73	$ 190.39	$ 187.43
71	$ 147.32	$ 145.03	$ 170.49	$ 167.83	$ 256.97	$ 252.98	$ 335.72	$ 330.50	$ 61.38	$ 60.43	$ 176.43	$ 173.69	$ 198.34	$ 195.25
72	$ 153.19	$ 150.80	$ 177.27	$ 174.52	$ 267.21	$ 263.05	$ 349.09	$ 343.66	$ 63.83	$ 62.83	$ 183.46	$ 180.61	$ 206.23	$ 203.03
73	$ 159.04	$ 156.57	$ 184.05	$ 181.19	$ 277.41	$ 273.10	$ 362.43	$ 356.79	$ 66.27	$ 65.24	$ 190.47	$ 187.51	$ 214.11	$ 210.78
74	$ 164.91	$ 162.34	$ 190.84	$ 187.87	$ 287.65	$ 283.18	$ 375.80	$ 369.96	$ 68.71	$ 67.64	$ 197.50	$ 194.43	$ 222.01	$ 218.56
75	$ 170.82	$ 168.17	$ 197.69	$ 194.61	$ 297.97	$ 293.34	$ 389.28	$ 383.23	$ 71.18	$ 70.07	$ 204.58	$ 201.40	$ 229.98	$ 226.40
76	$ 176.83	$ 174.08	$ 204.63	$ 201.45	$ 308.44	$ 303.64	$ 402.96	$ 396.69	$ 73.68	$ 72.53	$ 211.77	$ 208.48	$ 238.06	$ 234.36
77	$ 182.95	$ 180.11	$ 211.72	$ 208.43	$ 319.12	$ 314.16	$ 416.92	$ 410.43	$ 76.23	$ 75.04	$ 219.11	$ 215.70	$ 246.31	$ 242.48
78	$ 189.25	$ 186.30	$ 219.01	$ 215.60	$ 330.11	$ 324.97	$ 431.27	$ 424.56	$ 78.85	$ 77.63	$ 226.65	$ 223.12	$ 254.78	$ 250.82
79	$ 195.77	$ 192.72	$ 226.55	$ 223.03	$ 341.48	$ 336.17	$ 446.12	$ 439.19	$ 81.57	$ 80.30	$ 234.45	$ 230.81	$ 263.56	$ 259.46
80	$ 202.57	$ 199.42	$ 234.42	$ 230.77	$ 353.34	$ 347.84	$ 461.62	$ 454.44	$ 84.40	$ 83.09	$ 242.60	$ 238.83	$ 272.71	$ 268.47
81	$ 209.71	$ 206.45	$ 242.69	$ 238.91	$ 365.80	$ 360.11	$ 477.90	$ 470.47	$ 87.38	$ 86.02	$ 251.16	$ 247.25	$ 282.33	$ 277.94
82	$ 217.28	$ 213.90	$ 251.44	$ 247.53	$ 379.00	$ 373.11	$ 495.14	$ 487.44	$ 90.53	$ 89.12	$ 260.22	$ 256.17	$ 292.52	$ 287.97
83	$ 225.35	$ 221.84	$ 260.78	$ 256.73	$ 393.08	$ 386.96	$ 513.53	$ 505.55	$ 93.89	$ 92.43	$ 269.88	$ 265.68	$ 303.38	$ 298.67
84	$ 234.01	$ 230.37	$ 270.81	$ 266.60	$ 408.19	$ 401.85	$ 533.28	$ 524.99	$ 97.51	$ 95.99	$ 280.26	$ 275.90	$ 315.05	$ 310.15
85	$ 261.46	$ 257.39	$ 302.57	$ 297.86	$ 456.06	$ 448.97	$ 595.82	$ 586.55	$ 108.94	$ 107.25	$ 313.13	$ 308.26	$ 352.00	$ 346.52
86	$ 261.46	$ 257.39	$ 302.57	$ 297.86	$ 456.06	$ 448.97	$ 595.82	$ 586.55	$ 108.94	$ 107.25	$ 313.13	$ 308.26	$ 352.00	$ 346.52
87	$ 261.46	$ 257.39	$ 302.57	$ 297.86	$ 456.06	$ 448.97	$ 595.82	$ 586.55	$ 108.94	$ 107.25	$ 313.13	$ 308.26	$ 352.00	$ 346.52
88	$ 261.46	$ 257.39	$ 302.57	$ 297.86	$ 456.06	$ 448.97	$ 595.82	$ 586.55	$ 108.94	$ 107.25	$ 313.13	$ 308.26	$ 352.00	$ 346.52
89	$ 261.46	$ 257.39	$ 302.57	$ 297.86	$ 456.06	$ 448.97	$ 595.82	$ 586.55	$ 108.94	$ 107.25	$ 313.13	$ 308.26	$ 352.00	$ 346.52
90	$ 261.46	$ 257.39	$ 302.57	$ 297.86	$ 456.06	$ 448.97	$ 595.82	$ 586.55	$ 108.94	$ 107.25	$ 313.13	$ 308.26	$ 352.00	$ 346.52
91	$ 261.46	$ 257.39	$ 302.57	$ 297.86	$ 456.06	$ 448.97	$ 595.82	$ 586.55	$ 108.94	$ 107.25	$ 313.13	$ 308.26	$ 352.00	$ 346.52
92	$ 261.46	$ 257.39	$ 302.57	$ 297.86	$ 456.06	$ 448.97	$ 595.82	$ 586.55	$ 108.94	$ 107.25	$ 313.13	$ 308.26	$ 352.00	$ 346.52
93	$ 261.46	$ 257.39	$ 302.57	$ 297.86	$ 456.06	$ 448.97	$ 595.82	$ 586.55	$ 108.94	$ 107.25	$ 313.13	$ 308.26	$ 352.00	$ 346.52
94	$ 261.46	$ 257.39	$ 302.57	$ 297.86	$ 456.06	$ 448.97	$ 595.82	$ 586.55	$ 108.94	$ 107.25	$ 313.13	$ 308.26	$ 352.00	$ 346.52
95	$ 261.46	$ 257.39	$ 302.57	$ 297.86	$ 456.06	$ 448.97	$ 595.82	$ 586.55	$ 108.94	$ 107.25	$ 313.13	$ 308.26	$ 352.00	$ 346.52
96	$ 261.46	$ 257.39	$ 302.57	$ 297.86	$ 456.06	$ 448.97	$ 595.82	$ 586.55	$ 108.94	$ 107.25	$ 313.13	$ 308.26	$ 352.00	$ 346.52
97	$ 261.46	$ 257.39	$ 302.57	$ 297.86	$ 456.06	$ 448.97	$ 595.82	$ 586.55	$ 108.94	$ 107.25	$ 313.13	$ 308.26	$ 352.00	$ 346.52
98	$ 261.46	$ 257.39	$ 302.57	$ 297.86	$ 456.06	$ 448.97	$ 595.82	$ 586.55	$ 108.94	$ 107.25	$ 313.13	$ 308.26	$ 352.00	$ 346.52
99+	$ 261.46	$ 257.39	$ 302.57	$ 297.86	$ 456.06	$ 448.97	$ 595.82	$ 586.55	$ 108.94	$ 107.25	$ 313.13	$ 308.26	$ 352.00	$ 346.52

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

Apply a factor of 1.15 for Standard 1 Class rates


Geisinger Gold Medicare Supplement Rating Areas
Erie
Warren
McKean
Potter
Tioga
Bradford
Susquehanna
Wayne
Crawford
Forest
Cameron
Elk
Sullivan
Wyoming
Lackawanna
Pike
Venango
Mercer
Clarion
Jefferson
Clinton
Lycoming
Luzerne
Lawrence
Butler
Armstrong
Clearfield
Centre
Union
Montour
Columbia
Monroe
Carbon
Snyder
Northumberland
Schuylkill
Northampton
Beaver
Indiana
Cambria
Mifflin
Juniata
Dauphin
Lehigh
Allegheny
Westmoreland
Blair
Perry
Lebanon
Berks
Bucks
Huntingdon
Washington
Cumberland
Montgomery
Philadelphia
Somerset
Bedford
Fulton
Franklin
Adams
York
Lancaster
Chester
Delaware
Fayette
Greene
Area 1
Area 2
Area 3

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 classification and geographic rating area of the Commonwealth of Pennsylvania. Until you are age 99, your premium rate will change each year based on your attained age. This Premium rate change will be made on January 1st of each year the Policy remains in effect. Otherwise, your premium rate cannot change unless the Plan makes the same premium rate change for all Policies like yours in the classification and geographic rating area of the Commonwealth of Pennsylvania. Such classification and geographic rating area changes will be effective subject to the approval of the Pennsylvania Insurance Department. Schedules of rates may vary depending upon your Effective Date.

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
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
- First 60 days	All but $1340	$0	$1340 (Part A deductible)
- 61st through 90th day	All but $335 a day	$335 a day	$0
- 91st day and after:			
-- while using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
-- once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0**
- Beyond the additional 365 days	$0	$0	All costs
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
- 21st through 100th day	All but $167.50 a day	$0	Up to $167.50 a day
- 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 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 $183 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 $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B deductible)
- 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
- Next $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B deductible)
- Remainder of Medicare Approved Amounts	80%	20%	$0
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 services and medical supplies	100%	$0	$0
- Durable medical equipment			
- First $183 of Medicare Approved Amounts*	$0	$0	$183 (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
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
- First 60 days	All but $1340	$1340 (Part A deductible)	$0
- 61st through 90th day	All but $335 a day	$335 a day	$0
- 91st day and after:			
-- While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
-- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0**
- Beyond the additional 365 days	$0	$0	All costs
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
-21st through 100th day	All but $167.50 a day	$0	Up to $167.50 a day
-101st day and after	$0	$0	All costs
BLOOD			
-First 3 pints	$0	3 pints	$0
-Additional amounts	100%	$0	$0
HOSPICE CARE 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 $183 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 $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B deductible)
-- Remainder of Medicare 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
- Next $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B deductible)
- Remainder of Medicare Approved Amounts	80%	20%	$0
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 services and medical supplies	100%	$0	$0
- Durable medical equipment -- First $183 of Medicare Approved Amounts*	$0	$0	$183 (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 $1340	$1340 (Part A deductible)	$0
- 61st through 90th day	All but $335 a day	$335 a day	$0
- 91st day and after:			
-- While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
-- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0**
- Beyond the additional 365 days	$0	$0	All costs
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
- 21st through 100th day	All but $167.50 a day	Up to $167.50 a day	$0
- 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 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 C

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

*Once you have been billed $183 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 $183 of Medicare Approved Amounts*	$0	$183 (Part B deductible)	$0
- Remainder of Medicare 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
- Next $183 of Medicare Approved Amounts*	$0	$183 (Part B deductible)	$0
- Remainder of Medicare Approved Amounts	80%	20%	$0
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 services and medical supplies	100%	$0	$0
- Durable medical equipment			
-- First $183 of Medicare Approved Amounts*	$0	$183 (Part B deductible)	$0
-- Remainder of Medicare Approved Amounts	80%	20%	$0

GEISINGER GOLD MEDICARE SUPPLEMENT PLAN C

OTHER BENEFITS—NOT COVERED BY MEDICARE

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 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 $1340	$1340 (Part A deductible)	$0
- 61st through 90th day	All but $335 a day	$335 a day	$0
- 91st day and after:			
-- While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
-- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0**
- Beyond the additional 365 days	$0	$0	All costs
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
- 21st through 100th day	All but $167.50 a day	Up to $167.50 a day	$0
- 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 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 $183 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 $183 of Medicare Approved Amounts*	$0	$183 (Part B deductible)	$0
- Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
- First 3 pints	$0	All costs	$0
- Next $183 of Medicare Approved Amounts*	$0	$183 (Part B deductible)	$0
- Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR 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 services and medical supplies	100%	$0	$0
- Durable medical equipment			
-- First $183 of Medicare Approved	$0	$183 (Part B deductible)	$0
Amounts* -- Remainder of Medicare Approved	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

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 $183 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 $2240 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2240. 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.

SERVICES	MEDICARE PAYS	(AFTER YOU PAY $2240 DEDUCTIBLE,**) PLAN PAYS	(IN ADDITION TO $2240 DEDUCTIBLE,**) YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
- First 60 days	All but $1340	$1340 (Part A deductible)	$0
- 61st through 90th day	All but $335 a day	$335 a day	$0
- 91st day and after:			
-- While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
-- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0***
- Beyond the additional 365 days	$0	$0	All costs
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
- 21st through 100th day	All but $167.50 a day	Up to $167.50 a day	$0
- 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 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 $183 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 $2240 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2240. 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.

SERVICES	MEDICARE PAYS	(AFTER YOU PAY $2240 DEDUCTIBLE,**) PLAN PAYS	(IN ADDITION TO $2240 DEDUCTIBLE,**) 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 $183 of Medicare Approved Amounts*	$0	$183 (Part B deductible)	$0
- Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
- First 3 pints	$0	All costs	$0
- Next $183 of Medicare Approved Amounts	$0	$183 (Part B deductible)	$0
- Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

GEISINGER GOLD MEDICARE SUPPLEMENT HIGH DEDUCTIBLE PLAN F

PARTS A AND B

SERVICES	MEDICARE PAYS	(AFTER YOU PAY $2240 DEDUCTIBLE,**) PLAN PAYS	(IN ADDITION TO $2240 DEDUCTIBLE,**) YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment:			
-- First $183 of Medicare Approved Amounts*	$0	$183 (Part B deductible)	$0
-- Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	(AFTER YOU PAY $2240 DEDUCTIBLE,**) PLAN PAYS	(IN ADDITION TO $2240 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 $1340	$670 (50% of Part A deductible)	$670 (50% of Part A deductible)
- 61st through 90th day	All but $335 a day	$335 a day	$0
- 91st day and after:			
-- While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
-- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0**
- Beyond the additional 365 days	$0	$0	All costs
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
- 21st through 100th day	All but $167.50 a day	Up to $167.50 a day	$0
- 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 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 $183 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 $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B deductible)
- Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	Generally $0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
- First 3 pints	$0	All costs	$0
- Next $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B deductible)
- Remainder of Medicare Approved Amounts	80%	20%	$0
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 services and medical supplies	100%	$0	$0
- Durable medical equipment:			
-- First $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B deductible)
-- Remainder of Medicare Approved Amounts	80%	20%	$0

GEISINGER GOLD MEDICARE SUPPLEMENT PLAN M

OTHER BENEFITS—NOT COVERED BY MEDICARE

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 $1340	$1340 (Part A deductible)	$0
- 61st through 90th day	All but $335 a day	$335 a day	$0
- 91st day and after:			
-- While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
-- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0**
- Beyond the additional 365 days	$0	$0	All costs
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
- 21st through 100th day	All but $167.50 a day	Up to $167.50 a day	$0
- 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 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 $183 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 $183 of Medicare Approved Amounts*	$0	$0	$183 (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 $183 of Medicare Approved Amounts*	$0	$0	$183 (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 services and medical supplies	100%	$0	$0
- Durable medical equipment: -- First $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B deductible)
-- Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN N

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

Discrimination is against the law

Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company (the "Health Plan") comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation.

The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call the Health Plan at 800-447-4000 or TTY: 711.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with:

Civil Rights Grievance Coordinator
Geisinger Health Plan Appeals Department
100 North Academy Avenue, Danville, PA 17822-3220
Phone: 866-577-7733, TTY: 711
Fax: 570-271-7225
GHPCivilRights@thehealthplan.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Grievance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F
HHH Building, Washington, DC 20201
Phone: 800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 800-447-4000 or TTY: 711.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-447-4000 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-447-4000（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-447-4000 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-447-4000 (телетайп: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-447-4000 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-447-4000 (TTY: 711) 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-447-4000 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-447-4000 (رقم هاتف الصم والبكم:711.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-447-4000 (ATS : 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-447-4000 (TTY: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 800-447-4000 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-447-4000 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-447-4000 (TTY: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-447-4000 (TTY: 711)។

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-447-4000 (TTY: 711).