

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

Z	Basic,	including	100% Part B	comsurance,	except up to	\$20 copayment	For office	visit, and up to	\$50 copayment	For ER	Skilled	Nursing	Facility	Coinsurance	Part A	Deducible					Foreign Travel	Emergency					
M	Basic	Including	100% Part	E	Coinsurance						Skilled	Nursing	Facility	Coinsurance	50% Part A	Deducible					Foreign	Travel	Elliergency				
Γ	Hospitalization	and preventive	care paid at	100%; other	basic benefits	paid at 75%					75% Skilled	Nursing	Facility	Coinsurance	75% Part A	Deducible								Out-of-pocket	limit \$2780; paid	at 100% after limit	reached***
X	Hospitalization	and preventive	care paid at	100%; other	basic benefits	paid at 50%					50% Skilled	Nursing Facility	Coinsurance		50% Part A	Deducible								Out-of-pocket	limit \$5560; paid	at 100% after limit	reached***
Ŋ	Basic	Including	100% Part B	Comsurance							Skilled	Nursing	Facility	Coinsurance	Part A	Deducible			Part B Excess	(100%)	Foreign Travel	Emergency					
F F*	Basic	Including	100% Part B	Coinsurance							Skilled	Nursing	Facility	Coinsurance	Part A	Deductible	Part B	Deductible	Part B Excess	(100%)	Foreign Travel	Emergency					
D	Basic	Including	100% Part B	Comsurance							Skilled	Nursing	Facility	Coinsurance	Part A	Deducible					Foreign Travel	Emergency					
C	Basic	Including	100% Part B	Comsurance							Skilled	Nursing	Facility	Coinsurance	Part A	Deducible	Part B	Deductible			Foreign Travel	Emergency					
В	Basic	Including	100% Part B	Comsurance											Part A	Deducible											
A	Basic	Including	100% Part	Έ	Coinsurance				3																		

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 *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 \$2300 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed \$2300. Out-of-pocket expenses for this deductible are expenses that emergency deductible.

M-151-914-F Rev. 1/19

Monthly Rates Effective 1/1/2019 and subject to change

								(Alleg	(Allegheny, A	rmstr	ong, Bea	aver, E	Sutler	Area r, Fayette,	ea 1 tte, W	Armstrong, Beaver, Butler, Fayette, Washington and Westmoreland Counties)	ם ר	Westmo	reland	Countie	(SE								
		Plan ,	A			Plan B	8			Plan C	ပ			Pla	Plan F			Plan F HD	FHD			Plan M	N C			Ĕ	Plan N		
Attained	Ž	Male	Female	<u>a</u>	Male		Female		Male		Female	a	Š	Male	F	Female		Male	Female	ale	_ 2	Male	Fer	Female		Male	-	Female	ď
<65 <65		94	2	_		١.		6	1			က		288.96	S	284.47		50.59		49.80		150.04		147.71	ક	190.86	S	187.89	68
65	`			_		4		0					8	288.96		284.47	· 6	50.59		49.80	· 6	150.04	`	147.71	8	190.86		187.89	89
99								_	24					305.69	₩.	300.94	₩.	53.51		52.68	₩.	158.73	•	56.26	S	201.91		198.77	77
29					\$ 168.45									322.07		317.06	₩	56.38		55.51	8	167.23	•	164.63		212.73		209.42	42
89		140.35		138.16		36 \$		_			\$ 265.78			338.14		332.88	s	59.20		58.28	S	175.58		172.85		223.34		219.87	87
69						• •							8	353.95	↔	348.45	↔	61.96		61.00		183.79	•	180.93		233.78		230.15	15
70	∽ •		\$ 150		\$ 193.28			8 6	295.05	35		47	ო (369.54	∽ (363.80	↔ (64.69	⊕ (63.69	∽ •	191.88	⇔ (188.90	\$ €	244.08		240.29	53
1,7		159.78		157.30			198.22				302.59		÷ €	384.97	., €	378.99	∌ €	67.39		66.35		199.89		196.79		254.27	∙ •	250.32	3 5
73					5 209.37	× 5	21.00.12	_						400.30	e e	394.08	A 4	72.76		71.62		207.83	A 4	204.62	_	274.50	-	220.29	2 6
2.4			\$ 176			• • • •			6 K			72	. 4	430.93		424.23	÷ 49	75.44	· ·	74.27		223.76		220.28	•	284.63		280.20	20
75	-		·							41.		87	4	446.39		439.45	₩	78.15		76.93		231.79		228.18		294.84		290.26	26
9/	•		\$ 188		\$ 241.68	38	\$ 237.92	\$ 2	368.93			20	5 4	462.08		454.89	s	80.89	\$	79.63		239.93	8	236.20		305.20	↔	300.45	45
77						5 \$	\$ 246.17					78	4	478.08		470.65	8	83.69		82.39	\$	248.24		244.38		315.77	↔	310.86	98
78					\$ 258.66	36	5 254.64		394.85					494.54		486.85	s	86.57		85.23		256.78		252.79		326.64		321.56	26
62						37 \$	\$ 263.41			45 \$		10		511.57	↔	503.62	↔	89.56		88.16	↔	265.63	8	261.50		337.89		332.64	64
80						30	3 272.56	99	422.64			07	2	529.34		521.11	S	92.67		91.23	S	274.85		270.58		349.63		344.19	19
8					\$ 286.63	က္က တ	\$ 282.17	×	437.	22		12	ις.	548.01		539.49	٠	95.94	⊕	94.44	↔	284.55	\$	280.13		361.96		356.33	33
82			\$ 233			26	292.35	22	453.34	34 i	446.29	29	το ·	567.79		558.96	∽ •	99.40	٠ د	97.85	⇔ €	294.82		290.23		375.02	ω (369.19	19
8 83		244.41	24.	240.61	308.00	2 6	303.21	1 7	470.17	~ ·	462.86	98	ъ.	588.87	: → €	579.71	⊹ €	103.09	≓ ₹ ••••	101.49	. → ←	305.76	(€	301.01	•	388.95	•	382.90	06
85		233.01 4 283.58 9	27.5	279.07	357.35	ວັຕັ ວັຕ	351.80	• €	545.51	3 7	537.03	000	ى دە مىر	683 23	o 6	672.61	o 65	119.61	÷ ÷	117.75	o 6	354 76	o 6.	349.24		451.27	o 6.	297.03 444.25	3 5
98		283.58	\$ 275			35	351.80	8 0	545.	. 12		03	9	683.23		672.61	· 6	119.61	÷ ÷	117.75	· 6	354.76	· (,	349.24		451.27	θ.	444.25	25
87		283.58	\$ 27			35	351.80	80	545.51			03	3	683.23		672.61	↔	119.61	\$	17.75	&	354.76	↔	349.24		451.27	↔	444.25	25
88		283.58	\$ 273			35	351.80	\$ 00	545.			03	9	683.23		672.61	\$	119.61	\$	117.75	S	354.76	⇔	349.24		451.27	↔	444.25	25
88						35	351.80	8	545.51	51		03	9	683.23		672.61	s	119.61	\$	117.75	s	354.76	↔	349.24		451.27	↔	444.25	22
06						35	\$ 351.80	0	545.			33	9	683.23		672.61	↔	119.61	\$	117.75	↔	354.76	ω.	349.24	_	451.27	↔	444.25	22
91						ξ, , (351.80	<u>ه</u>	545.			89	9	683.23		672.61	φ,	119.61	⇔	117.75	φ.	354.76	(,)	349.24		451.27	↔	444.25	22
92			\$ 279		\$ 357.35	ž Š	351.80	9 9	545.51	 		03	ں د	683.23		672.61	↔ €	119.61	÷ ÷	117.75	φ.	354.76	., с •	349.24		451.27	φ (444.25	25
		283.58	77 0			ຽ່	351.80	2 6	245.5	·	537.03	200	ים	083.23		0.770	₽ €	1.9.0.1	- ₹ • •	77.75	₽ €	354.75	, c	349.24		451.27	∌ €	444.25	υ i
9 Q		283.58	277	279.17		ຽ້	351.80	2 6	240.		537.03	200	י פ	663.23	∌ €	672.61	∌ €	119.61	- ÷	117.75	∌ €	354.76	∌ €	349.24	A 6	451.27		444.25	2 2
င္တ		-			357.35	ק	351.00	2 5	545.51	2 12	537.03	3 6	ى د سىم	683.23		672.61	o 4	119.61	- `	117.75		354.76	, (·	349.24		451.27	9 6	444.23	22
26						35.	351.80	9 0	545.51	5.72		03		683.23		672.61	↔	119.61	• ←	117.75	↔	354.76	· •	349.24		451.27		444.25	25
86						35	351.80	00	545.			03	9	683.23	ω	672.61	· 6	119.61	8	117.75	· 6 9	354.76	· (,	349.24		451.27	8	444	25
+66		283.58	\$ 279.	9.17	\$ 357.3	.35	351.8	80	542	.51		03	9	683.23	S	672.61	S	119.61	\$	117.75	S	354.76	€9	349.24	S	451.27	S	444.	25

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
Form Numbers: M-151-912-F Rev. 1/18, M-152-099-F Rev. 1/18, M-151-915-F Rev. 1/18, M-151-916-F Rev. 1/18, M-151-919-F Rev. 1/18, M-151-919-F Rev. 1/18

Monthly Rates Effective 1/1/2019 and subject to change

									(Buck	s, Ch	Area 2 (Bucks, Chester, Deleware, Montgomery and Philadelphia Counties)	war	Area 2 e, Montgome	a 2 mery a	nd Phi	ladelpł	ia Coun	ties)									
		Plan A	4		Pla	Plan B			Plan C	J C			Plan F	Ь			Plan F HD	Н			Plan M	M			Plan N	Z	
Attained	Σ	Male	Female		Male	Ш	Female		Male	ı,	Female	2	Male	Female	e	Z	Male	Female		Male		Female	<u> </u>	Š	Male	Ę.	Female
<65 <65		15		2		es	154.16	es	235.81		232.14	es.	14		290.81		72		Н		1.		.62		194.60		191.57
65		. LC		. rc		₩	154.16	₩.	235.81	· 69	232.14	· 6A		\$ 290	290.81				. 4			•	153.62		194.60	· 69	191.57
99	· •	136.63 \$				• •	163.08	,	249.46	· (245.58	· 69			307.65	· •		\$ 53.86			* * 8 8		162.52	· 8	205.86		202.66
29	€		141			6	171.82	s	262.83	S	258.74	s	329.25		324.13				വ	173.93			171.22		216.89		213.52
89	↔					s	180.39	s	275.94	₩	271.65	s	345.68		340.30		60.52		⇔	182.61			179.77		227.71		224.17
69	∽					₩	188.83	8	288.84	₩	284.35	s	361.84		356.21				9	191.15			3.17		238.36		234.65
20				9		↔	197.14	↔	301.57	↔	296.88	\$	377.78	\$ 37	371.91				-	199.57	27 \$		196.46		248.86		244.99
7.1						₩.	205.38	₩.	314.16	₩.	309.27	₩.	393.56	88	387.44				ა	207.90			.67		259.25		255.22
72						↔	213.55	φ,	326.67	s ·	321.59	∽	409.23	\$ 40	402.86				හ ල	216.18			.82		269.57		265.38
73						φ.	221.71	↔	339.15	↔	333.88	⇔ •	424.86	8	418.26				က	224.44			.95		279.87		275.52
74						()	229.90	ഗ (351.67	⇔ (346.20	ഗ (440.54	\$ 43	433.69				හ ල	232.72			229.10	s 6	290.20		285.69
75						₩ (238.14	φ.	364.28	ω.	358.62	⇔ (456.35	\$ 44	449.25				2	241.07			237.32		300.61	٠. د	295.94
92						()	246.51	ω (377.08	↔ (371.21	⊕ (472.38	\$ 46.	465.03				S .	249.54			99.		311.17		306.33
77						⇔ (255.05	د	390.14	⇔ (384.07	⇔ •	488.74	\$ 48	481.14				4 ·	258.18			.17		321.95		316.95
78						₩ (263.83	₩ (403.57	⇔ (397.29	₩ (505.56	\$ 49	497.70			\$ 87.13	ა	267.07			.92		333.03		327.86
79						₩.	272.91	so ·	417.47	₩.	410.98	₩.	522.98	\$ 51	514.84				4 &	276.27			.97		344.51	₩.	339.15
80						↔ (282.39	ഗ (431.97	↔ •	425.25	⊕ (541.14	\$ 53.	532.73		94.74	\$ 93.27	S (285.86			42		356.47	⇔ (350.93
84						9	292.36	9	447.21	s (440.26	s (560.23	\$ 22	551.52		98.08	96.56	9	295.95			291.35		369.05		363.31
82						₩ (302.90	⇔ €	463.34	⇔ €	456.14	⇔ €	580.44	\$ 57	571.42		101.62	100.04	4 o	306.62			301.86		382.36	⇔ (376.42
83		263.20 \$				∙ •	314.15	÷ €	480.55		473.08		602.00	29.	592.64	÷ ÷	105.39	103.76	9 E	318.01	5 6	_	.07	_	396.56	÷ €	390.39
84 95		213.32 \$	200.62	A 6	321.39	A 6	320.24	A 6	499.03	A 6	77.184	A 4	072.13	- 0 0 0	607.60	ج د	09.45	107.75	ტ ც	350.24	4 t	363.73	- 6	ծ գ 4 ∠	18.1.8	n 6	405.41
S &		305.37	300.02)	364.49)	557.55	→ 4:	240.00	→	698.46	9 6	687.60	- 、		120.38	9 6	368 97	- 6	363.23	3 6		460.11	• •	452 95
87		305.37	300.62			θ.	364 49	υ.	557.55	· (248	· •	698 46	9 6	687.60			-) or	368.97	- 6	363	363.23		460 11	· •	452.95
. 88		305.37 \$				₩	364.49	↔	557.55	₩	548.88	· 69	698.46	\$ 68	687.60	₩ ₩	22.28	120.38	· ω	368.97	\$ 26	363	363.23	÷ &	460.11	· • •	452.95
88			300.62			s	364.49	s	557.55	s	548.88	s	698.46	\$ 68	09.789	_	22.28	\$ 120.38	8	368.97	\$ 26		363.23		460.11	φ.	452.95
06			300.62			ઝ	364.49	ઝ	557.55	s	548.88	s	698.46	\$ 68	09.789	\$	22.28	\$ 120.38	8	368.97	\$ 26	363	363.23	\$	460.11	` \$	452.95
91						↔	364.49	s	557.55	S	548.88	₩.	698.46	\$ 68	09.789	_	22.28	\$ 120.38	ω	368.97	37 \$	363.23	.23		460.11	٠ &	452.95
92		305.37 \$		2		()	364.49	s	557.55	S	548.88	↔	698.46	\$ 68	09'289	_	22.28	\$ 120.38	φ •	368.97	\$ 26	363.23	.23		460.11	• •>	452.95
93		305.37 \$	300.62			s ·	364.49	s ·	557.55	s ·	248.88	s ·	698.46	\$ 68	09.789	_	22.28	\$ 120.38	φ •	368.97	97 \$	363	363.23		460.11	s S	452.95
94						φ.	364.49	↔	557.55	φ.	248.88	s e	698.46	\$ 68	687.60	_	22.28	\$ 120.38	φ ·	368.97			363.23		460.11	· •	452.95
92						φ.	364.49	s ·	557.55	φ.	248.88	⇔ •	698.46	\$ 68	687.60	_	22.28	\$ 120.38	φ ·	368.97			363.23		460.11	· •	452.95
96						s ·	364.49	s ·	557.55	φ.	248.88	s ·	698.46	\$ 68	687.60	₩.	122.28	\$ 120.38	φ •	368.97	\$ 2		363.23		460.11	s S	452.95
97		37				ഗ (364.49	φ.	557.55	⇔ 4	548.88	\$ (698.46	\$ 68	687.60	ج ج	22.28	\$ 120.38	& ·	368.97	97 \$	363.23	.23		460.11	٠ ن	452.95
86		305.37 \$	300	2 0	370	↔ •		↔ •	557.55	⊕ (548.88	⇔ 4	698.46	89 8	687.60	∵ ;	22.28	120.38	<u>∞</u> .	368.97	97 \$	363.23	.33	æ 6	460.11	· •> •	452.95
+66		305.37 \$	300.62	4	370.25	S	364.49	Ð	557.55	S)	548.88	€	698.46	\$ 68	687.60	.	22.28	5 120.38	∌	368.97	97	363.23	.23		460.11	· •	452.95

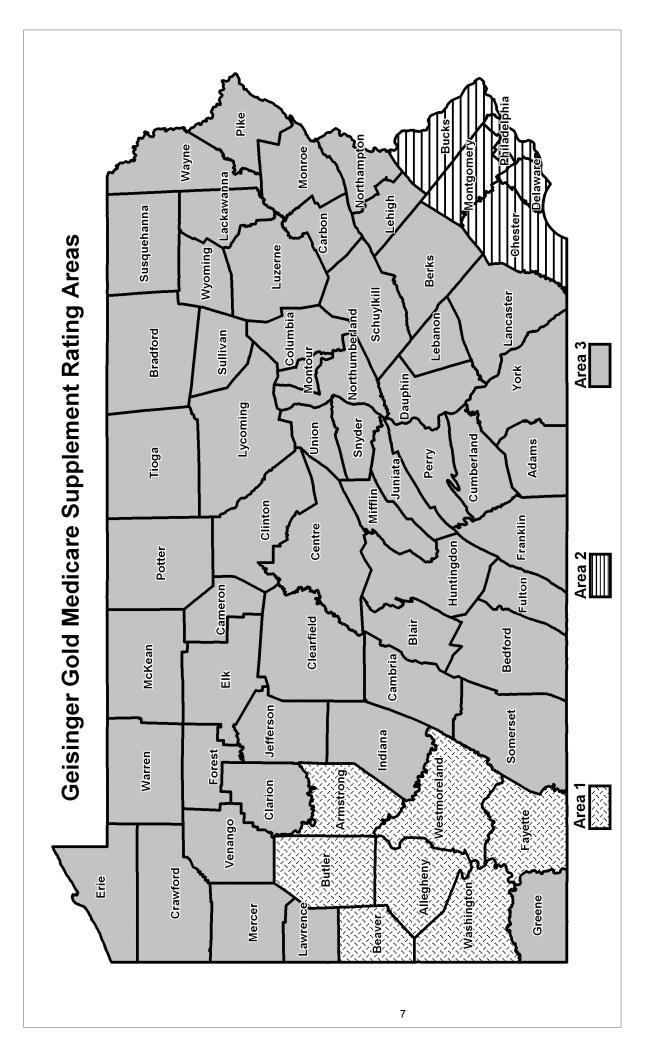
All open enrollment and guaranteed issue insureds will be rated using the Preferred rates above.
Apply a factor of 1.15 for Standard 1 Class rates
Form Numbers: M-151-912-F Rev. 1/18, M-152-099-F Rev. 1/18, M-151-915-F Rev. 1/18, M-151-916-F Rev. 1/18, M-151-919-F Rev. 1/18, M-151-919-F Rev. 1/18

Monthly Rates Effective 1/1/2019 and subject to change

Greene, erland,		Female	165.90	165.90	175.51	184.91	194.14	203.21	212.17	221.03	229.83	238.61	247.41	250.29	87.007	283.93	293.71	303.91	314.63	325.98	338.09	351.09	392.26	392.26	392.26	392.26	392.26	392.26	392.26	392.26	392.26	392.26	392.26	392.26	392.26	392.26	392.26
ulton, humb	Plan N		8		· \$									+ ~					\$	⇔ ∝	⇔ ∽	\$	8	8	\$	\$	\$	\$	8	8	\$	& %	& %	8	\$	& ·	8
nklin, Fu on, Nort	Ь	Male	168.52	168.52	178.28	187.83	197.20	206.42	215.52	224.52	233.46	242.38	251.32	260.34	070.40	288 41	298.35	308.71	319.60	331.13	343.43	356.64	398.46	398.46	398.46	398.46	398.46	398.46	398.46	398.46	398.46	398.46	398.46	398.46	398.46	398.46	398.46
t, Fra lampt es)			_	€		s		↔			φ (A 6)	↔	₩.	s	8	↔	છ	8	ઝ	↔	↔	↔	↔	↔	↔	↔	↔	↔	\$	↔	↔	ક્ર
ie, Fores ır, North < Countii		Female	132.20	132.20	139.85	147.34	154.70	161.93	169.06	176.12	183.14	190.13	797.75	211 40	010 70	226.25	234.04	242.17	250.71	259.76	269.40	279.76	312.57	312.57	312.57	312.57	312.57	312.57	312.57	312.57	312.57	312.57	312.57	312.57			312.57
k, Eri ontou I York	In M	ŭ	s	s	₩	s	↔	↔	φ.	₩ (φ (,	∌ 6	9 4	9 6)	↔	₩.	s	↔	s	s	8	8	↔	↔	↔	s	8	↔	↔	s	↔	↔	↔	↔	s
uphin, El onroe, M ming and	Plan	Male	134.29	134.29	142.06	149.67	157.14	164.49	171.73	178.90	186.03	193.14	200.26	24.702	222.47	229.82	237.74	245.99	254.67	263.86	273.66	284.18	317.51	317.51	317.51	317.51	317.51	317.51	317.51	317.51	317.51	317.51	317.51	317.51	317.51	317.51	317.51
d, Da in, M			s	မ	φ.	s	↔	ss ·	φ.	₩ (↔ (A	∌ 6	9 6	9 6)	↔	ω.	s	s	s	s	s	s	↔	↔	↔	&	છ	↔	&	↔	s	ઝ	↔	s	s
, Columbia, Crawford, Cumberland, Dauphin, Elk, Erie, Forest, Franklin, Fulton, Greene, Lycoming, McKean, Mercer, Mifflin, Monroe, Montour, Northampton, Northumberland, Union, Venango, Warren, Wayne, Wyoming and York Counties)	•	Female	45.31	45.31	47.94	50.50	53.02	55.50	57.95	60.37	62.77	65.17	67.58	72.46	74.40	77.55	80.22	83.01	85.93	89.03	92.34	95.89	107.14	107.14	107.14	107.14	107.14	107.14	107.14	107.14	107.14	107.14	107.14	107.14	107.14	107.14	107.14
rd, Cu , Mei arren	F HD	Ľ		s	φ.	s	₩	↔	↔ (₩ (↔ •	→ •	, 6	9 4	9 6)	↔	φ.	s	8	\$	\$	\$	s	↔	↔	\$	s	↔	\$	s	s	↔	s	\$	S	S
, Crawfoı , McKear ıango, W	Plan	Male	46.03	46.03	48.69	51.30	53.86	56.38	58.86	61.32	63.76	66.20	68.64	73.60	76.45	78.77	81.49	84.32	87.29	90.44	93.80	97.41	108.83	108.83	108.83	108.83	108.83	108.83	108.83	108.83	108.83	108.83	108.83	108.83	108.83	108.83	108.83
Columbia, Lycoming, Jnion, Venz		_	s	s	φ.	s	↔	↔	↔ (₩ (↔ •	→ •	, 6	9 6	9 6	→ (:	↔	ω.	s	s	s	s	s	s	↔	↔	s	↔	s	s	↔	s	↔	↔	↔	↔	S
		Female	253.29	253.29	267.95	282.30	296.39	310.25	323.92	337.44	350.88	364.28	377.73	391.20	400.02	433.48	448.41	463.98	480.35	497.68	516.16	536.01	598.87	598.87	598.87	598.87	598.87	598.87	598.87	598.87	598.87	598.87	598.87	598.87	598.87		598.87
ea 3 I, Clir Luze a, Tio	lan F	ŭ		s	€	s	8	8	↔ (₩ (φ (∙	,	9 6	9 6)	↔	·	s	s	છ	\$	\$	&	8	S	8	↔	↔	8	↔	s	↔	8	s)	S	S
Area 3 , Carbon, Centre, Clarion, Clearfield, Clinton, saster, Lawrence, Lebanon, Lehigh, Luzerne, er, Somerset, Sullivan, Susquehanna, Tioga,	Pla	Male	257.29	257.29	272.18	286.76	301.07	315.15	329.03	342.77	356.42	3/0.04	383.69	097.750	75.1.4	440.32	455.49	471.31	487.94	505.54	524.32	544.48	608.33	608.33	608.33	608.33	608.33	608.33	608.33	608.33	608.33	608.33	608.33	608.33	608.33	608.33	608.33
rion, anon , Sus			s	s	₩	s	s	↔	ഗ (₩ (, 6) ₩	↔																		\$	s	s
entre, Cla ence, Leb t, Sullivan		Female	202.23	202.23	213.93	225.40	236.65	247.71	258.62	269.42	280.15	290.85	301.58	202.20	224 50	346.10	358.02	370.45	383.52	397.36	412.12	427.97	478.15	478.15	478.15	478.15	478.15	478.15	478.15	478.15	478.15	478.15	478.15	478.15	478.15	478.15	478.15
on, Co Lawr Ierse	an C		S	S			↔				•				. •)		٠,																	↔		
on, Carbon, Centre, ncaster, Lawrence, der, Somerset, Sull	Plaı	Male		205.42	217.31	228.96	240.38	251.62	262.71	273.68	284.57	295.45	306.35	208 40	220.43	351.56	363.67	376.31	389.58	403.63	418.63	434.73	485.70	485.70	485.70	485.70	485.70	485.70	485.70	485.70	485.70	485.70	485.70	485.70	485.70	485.70	485.70
amer na, La I, Sny			s				↔																_								↔	↔	ઝ	↔	↔	↔	₩
mbria, Cackawanr Schuylkil		Female	132.02	132.02	139.67	147.15	154.49	161.72	168.84	175.89	182.89	189.88	196.89	211 12	21012	225.95	233.73	241.85	250.38	259.41	269.05	279.40	312.16	312.16	312.16	312.16	312.16	312.16	312.16	312.16	312.16	312.16	312.16	312.16	312.16	312.16	312.16
d, Ca ta, La	Plan B			s	₩	s		↔			₩ (↔			↔	ઝ				↔						↔					()	₩
, Blair, Bradford, Cambria, Cameron efferson, Juniata, Lackawanna, Lanc Perry, Pike, Potter, Schuylkili, Snyd	Pi	Male	134.11	134.11	141.87	149.47	156.93	164.27	171.51	178.67	185.78	192.88	200.00	21.17	22.4.40	229.52	237.42	245.67	254.34	263.51	273.30	283.81	317.09	317.09	317.09	317.09	317.09	317.09	317.09	317.09	317.09	317.09	317.09	317.09	317.09	317.09	317.09
, Blai effers Perry			Н				↔																														-
(Adams, Bedford, Berks, Blair, Bradford, Cambria, Cameron, Carbon, Centre, Huntingdon, Indiana, Jefferson, Juniata, Lackawanna, Lancaster, Lawrence, Perry, Pike, Potter, Schuyikili, Snyder, Somerset, Sull	1	Female	108.32	108.32	114.59	120.73	126.75	132.68	138.52	144.30	150.05	155.78	161.53	172.20	170.20	185.37	191.76	198.42	205.42	212.83	220.73	229.22	256.10	256.10	256.10	256.10	256.10	256.10	256.10	256.10	256.10	256.10	256.10	256.10	256.10	256.10	256.10
sedfo Ion, I	Plan A		8				\$																							⇔						⇔	
Adams, E Huntingd	Ь	Male	110.03	110.03	116.40	122.63	128.75	134.77	140.71	146.58	152.42	158.24	164.08	175.07	10.04	188.30	194.79	201.55	208.66	216.19	224.22	232.84	260.15	260.15	260.15	260.15	260.15	260.15	260.15	260.15	260.15	260.15	260.15	260.15	260.15	260.15	260.15
			8	↔	₩	S	↔	↔	₩ (₩ (↔ •	→ (^ 6	9 6	9 6)	↔	₩	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	ઝ
		Attained Age	, 65	65	99	29	99	69	0 i	71	75	e :	4 7	67	19	- 22	62	8	8	82	83	84	82	98	87	88	68	06	91	95	93	94	92	96	26	86	+66

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
Form Numbers: M-151-912-F Rev. 1/18, M-152-099-F Rev. 1/18, M-151-916-F Rev. 1/18, M-151-917-F Rev. 1/18, M-151-919-F Rev. 1/18, M-151-919-F Rev. 1/18



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*	WEDICAKETATS	ILANTAIS	TOUTAL
Semiprivate room and board,			
general nursing and			
miscellaneous services and			
supplies			
- First 60 days	All but \$1364 All	\$0	\$1364 (Part A deductible)
- 61 st through 90 th day	but \$341 a day	\$341 a day	\$0
	l and the many	, and	
- 91 st day and after:			
while using 60 lifetime	All but \$682 a day	\$682 a day	\$0
reserve days			
once lifetime reserve			
days are used:			
- Additional 365 days	\$0	100% of Medicare eligible	\$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 three days and			
entered a Medicare-approved			
facility.			
Within 30 days after leaving			
the hospital:			
- First 20 days	All approved amounts	\$0	\$0
	TT TO THE TOTAL OF		
- 21 st through 100 th day	All but \$170.50 a day	\$0	Up to \$170.50 a day
- 101 st day and after	\$0	\$0	All costs
BLOOD			
- First 3 pints	\$0	3 pints	\$0
- Additional amounts	100%	\$0	\$0
HOSPICE CARE		* -	7 -
You must meet Medicare's	All but very limited	Medicare	\$0
requirements, including a	copayment/coinsurance	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 A

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

*Once you have been billed \$185 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 \$105 of Medicans Ammoused	\$0	00	\$195 (Dowt D. doductible)
- First \$185 of Medicare Approved Amounts*	\$0	\$0	\$185 (Part B deductible)
Amounts			
- 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	40	40	\$405 (D.) D. 1. 1. 1. 1. 1. 1.
- Next \$185 of Medicare Approved	\$0	\$0	\$185 (Part B deductible)
Amounts*			
- Remainder of Medicare Annroyed	80%	20%	80
**	00/0	20/0	ΨΟ
	100%	\$0	80
Amounts* - Remainder of Medicare Approved Amounts CLINICAL LABORATORY SERVICES -TESTS FOR DIAGNOSTIC SERVICES	80%	20%	\$0 \$0

PARTS A and B

SERVICES	MEDICARE	PLAN PAYS	YOU PAY
	PAYS		
HOME HEALTHCARE			
MEDICARE APPROVED SERVICES			
- Medically necessary skilled care			
services and medical supplies	100%	\$0	\$0
- Durable medical equipment - First \$185 of Medicare Approved Amounts*	\$0	\$0	\$185 (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 \$1364	\$1364 (Part A deductible)	\$0
- 61 st through 90 th day	All but \$341 a day	\$341 a day	\$0
- 91 st day and after:			
While using 60 lifetime	All but \$682 a day	\$682 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.	All commerced conscients	\$0	\$0
-First 20 days	All approved amounts	\$0	\$0
-21 st through 100 th day	All but \$170.50 a day	\$0	Up to \$170.50 a day
21 mough 100 day	Thi out \$170.50 a day		ερ το φ1 / ο.ε ο α αα γ
-101 st 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			

^{**}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 \$185 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 \$185 of Medicare			
Approved Amounts*	\$0	\$0	\$185 (Part B deductible)
D : 1 01/1	G 11 000/	G 11 200/	
Remainder of Medicare	Generally 80%	Generally 20%	\$0
Approved Amounts			
Part B Excess Charges	40	40	
(Above Medicare Approved	\$0	\$0	All costs
Amounts)			
BLOOD	0.0	4.11	0.0
- First 3 pints	\$0	All costs	\$0
- Next \$185 of Medicare	\$0	\$0	\$185 (Part B deductible)
Approved Amounts*	\$0	\$0	\$183 (Fait B deductible)
Approved Amounts			
- 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 services and medical supplies -Durable medical equipment First \$185 of Medicare	100%	\$0	\$0
Approved Amounts* Remainder of Medicare	\$0	\$0	\$185 (Part B deductible)
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 \$1364	\$1364 (Part A deductible)	\$0
- 61 st through 90 th day	All but \$341 a day	\$341 a day	\$0
- 91 st day and after:			
While using 60 lifetime reserve days	All but \$682 a day	\$682 a day	\$0
Once lifetime reserve			
days are used:			
- Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
- 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			
- First 20 days	All approved amounts	\$0	\$0
- 21st through 100th day	All but \$170.50 a day	Up to \$170.50 a day	\$0
- 101 st 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	\$0
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 \$185 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:	40	0105 (D.) D. 1. 1. 111.	4.0
- First \$185 of Medicare Approved	\$0	\$185 (Part B deductible)	\$0
Amounts*	C 11 000/	C - 11 - 200/	60
- Remainder of Medicare Approved	Generally 80%	Generally 20%	\$0
Amounts			
Part B Excess Charges	\$0	\$0	All costs
(Above Medicare Approved Amounts)	\$0	30	All costs
BLOOD			
First 2 mints	\$0	All costs	\$0
First 3 pintsNext \$185 of Medicare Approved	\$0	\$185 (Part B deductible)	\$0
Amounts*			
- Remainder of Medicare Approved	80%	20%	\$0
Amounts CLINICAL LABORATORY			
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC	100%	\$0	\$0
SERVICES—TESTS FOR DIAGNOSTIC SERVICES	10070	ΦU	Φ0

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 \$185 of Medicare Approved	\$0	\$185 (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 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 \$1364	\$1364 (Part A deductible)	\$0
- 61 st through 90 th day	All but \$341 a day	\$341 a day	\$0
- 91 st day and after:	A 11.1	Φ. (1)	Φ0
While using 60 lifetime	All but \$682 a day	\$682 a day	\$0
reserve days			
Once lifetime reserve			
days are used:	\$0	100% of Madiagra aligible	\$0**
- Additional 365 days	\$0	100% of Medicare eligible	\$0
Dayand the additional	\$0	expenses \$0	All costs
- Beyond the additional	\$0	30	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:			
- First 20 days	All approved amounts	\$0	\$0
	11		
- 21 st through 100 th day	All but \$170.50 a day	Up to \$170.50 a day	\$0
	•		
- 101 st 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	\$0
requirements, including a	copayment/coinsurance		
doctor's certification of	for outpatient drugs		
terminal illness.	and 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 F

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

*Once you have been billed \$185 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 \$185 of Medicare	\$0	\$185 (Part B deductible)	\$0
Approved Amounts*			
5	G 11 000/	G 11 200/	40
- Remainder of Medicare	Generally 80%	Generally 20%	\$0
Approved Amounts			
Part B Excess Charges	0.0	1000/	0.0
(Above Medicare Approved	\$0	100%	\$0
Amounts)			
BLOOD	00	A 11	00
- First 3 pints	\$0	All costs	\$0
- Next \$185 of Medicare	\$0	\$195 (Dort D. doductible)	\$0
	\$0	\$185 (Part B deductible)	\$0
Approved Amounts*			
- Remainder of Medicare	80%	20%	\$0
Approved Amounts	0070	2070	ΨΟ
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	100%	\$0	\$0
services and medical supplies			
- Durable medical equipment			
First \$185 of Medicare Approved	\$0	\$185 (Part B	\$0
		deductible)	
Amounts*	80%	20%	\$0
Remainder of Medicare Approved			

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 \$185 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 \$2300 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2300. 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	plan's separate foreign travel (MEDICARE PAYS	(AFTER YOU PAY	(IN ADDITION TO
SERVICES	WIEDICARE FATS	\$2300	(IN ADDITION TO \$2300
		DEDUCTIBLE,**)	DEDUCTIBLE,**) YOU
HOCDITALIZATIONS		PLAN PAYS	PAY
HOSPITALIZATION*			
Semiprivate room and board,			
general nursing and			
miscellaneous services and			
supplies	A11.1 + 01.2.64	\$1264 (D + A 1 1 + (31))	Φ0
- First 60 days	All but \$1364	\$1364 (Part A deductible)	\$0
- 61 st through 90 th day	All but \$341 a day	\$341 a day	\$0
- 91 st day and after:	A11 1 0000 - 1	¢(02 - 1	\$0
While using 60 lifetime	All but \$682 a day	\$682 a day	\$0
reserve days Once lifetime reserve			
days are used:			
3	\$0	100% of Medicare eligible	\$0***
- Additional 365 days	\$0	_	\$0
- Beyond the additional	\$0	expenses \$0	All costs
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
	NFF THE STATE OF		·
- 21 st through 100 th day	All but \$170.50 a day	Up to \$170.50 a day	\$0
- 101 st 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	\$0
requirements, including a	copayment/coinsurance for	copayment/coinsurance	
doctor's certification of	outpatient 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 HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed \$185 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 \$2300 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2300. 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 \$2300	(IN ADDITION TO \$2300
		DEDUCTIBLE,**) PLAN PAYS	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 \$185 of Medicare	\$0	\$185 (Part B deductible)	\$0
Approved Amounts*			
- Remainder of Medicare	Generally 80%	Generally 20%	\$0
Approved Amounts	, , , , , , , , , , , , , , , , , , , ,	J	
Part B Excess Charges			
(Above Medicare Approved	\$0	100%	\$0
Amounts)			
BLOOD	Φ0	A 11	Φ0
- First 3 pints	\$0	All costs	\$0
- Next \$185 of Medicare	\$0	\$185 (Part B deductible)	\$0
Approved Amounts	~~	(Tart 2 deductions)	* * *
rr			
- Remainder of Medicare	80%	20%	\$0
Approved Amounts			
CLINICAL LABORATORY			
SERVICES—TESTS FOR	1000/	, do	Φ0
DIAGNOSTIC SERVICES	100%	\$0	\$0

GEISINGER GOLD MEDICARE SUPPLEMENT HIGH DEDUCTIBLE PLAN F

PARTS A AND B

SERVICES	MEDICARE PAYS	(AFTER YOU PAY \$2300 DEDUCTIBLE,**) PLAN PAYS	(IN ADDITION TO \$2300 DEDUCTIBLE,**) YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- Durable medical equipment: First \$185 of Medicare Approved Amounts*	\$0	\$185 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

SERVICES	MEDICARE PAYS	(AFTER YOU PAY \$2300 DEDUCTIBLE,**) PLAN PAYS	(IN ADDITION TO \$2300 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	20% and amounts over the
		maximum benefit of \$50,000	\$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 \$1364	\$682 (50% of Part	\$682 (50% of Part
		A deductible)	A deductible)
- 61 st through 90 th day	All but \$341 a day	\$341 a day	\$0
- 91 st day and after:			
While using 60 lifetime	All but \$682 a day	\$682 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:		do o	4.0
- First 20 days	All approved amounts	\$0	\$0
- 21 st through 100 th day	All but \$170.50 a day	Up to \$170.50 a day	\$0
- 101 st day and after	\$0	\$0	All costs
BLOOD	CO	2	¢0
- First 3 pints	\$0 100%	3 pints \$0	\$0 \$0
- Additional amounts HOSPICE CARE		Φ U	⊅ ∪
You must meet Medicare's	All but very limited	Medicare	\$0
	co-payment/ coinsurance for		Φ
requirements, including a doctor's certification of terminal	outpatient drugs and	copayment/coinsurance	
illness	inpatient respite care		
IIIICSS	impatient 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 M

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

*Once you have been billed \$185 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 \$185 of Medicare	\$0	\$0	\$185 (Part B
Approved Amounts*			deductible)
- 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 \$185 of Medicare	\$0	\$0	\$185 (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 \$185 of Medicare	\$0	\$0	\$185 (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	20% and amounts over the
		maximum benefit of	\$50,000 lifetime maximum
		\$50,000	

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 \$1364	\$1364 (Part A deductible)	\$0
- 61 st through 90 th day	All but \$341 a day	\$341 a day	\$0
- 91 st day and after:			
While using 60 lifetime	All but \$682 a day	\$682 a day	\$0
reserve days	•		
Once lifetime reserve days are			
used:			
- Additional 365 days	\$0	100% of Medicare eligible	\$0**
- Beyond the additional 365	\$0	expenses \$0	All costs
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
- 21 st through 100 th day	All but \$170.50 a day	Up to \$170.50 a day	\$0
- 101 st 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		
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		

^{**} 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 \$185 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 \$185 of Medicare Approved Amounts*	\$0	\$0	\$185 (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 \$185 of Medicare Approved Amounts*	\$0	\$0	\$185 (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			
D 11 1: 1 :			
- Durable medical equipment:	Φ0	Φ0	Φ10.7 (D + D
First \$185 of Medicare	\$0	\$0	\$185 (Part B
Approved Amounts*			deductible)
Remainder of Medicare	80%	20%	\$0
Approved Amounts	00/0	20/0	φυ
Approved Amounts			

PLAN N

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