Group Health Incorporated ("GHI"), an EmblemHealth Company
55 Water Street, New York, NY 10041-8190

Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make available Plans "A" & "B" and either "C" or "F". Some plans may not be available in your state.

Basic Benefits:

- **Hospitalization** – Part A coinsurance plus coverage for 365 additional days in your lifetime 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.

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 Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit $5,560; paid at 100% after limit reached	Out-of-pocket limit $2,780; 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 $2,300. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2,300 for 2019. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

PREMIUM INFORMATION

We, Group Health Incorporated, an EmblemHealth company (hereafter referred to as "EmblemHealth") can only raise your premium if we raise the premium for all policies like yours in this geographic region.

EmblemHealth Medicare Supplement Insurance 2019 monthly premium rates (per individual):

Region	Plan A	Plan B	Plan C	Plan F	Plan F+
Albany	$185.48	$242.45	$288.56	$508.59	$71.46
Buffalo	$175.46	$229.40	$272.95	$481.07	$67.43
Downstate	$194.87	$253.28	$300.87	$530.29	$74.00
Mid-Hudson	$185.48	$242.45	$288.56	$508.59	$71.46
Rochester	$175.46	$229.40	$272.95	$481.07	$67.59
Syracuse	$181.39	$237.12	$282.08	$497.18	$69.86
Utica/Watertown	$175.46	$229.40	$272.95	$481.07	$67.59

The following is a breakdown of counties in each region:

Downstate: Bronx, Kings, Nassau, Manhattan, Queens, Richmond, Rockland, Suffolk and Westchester.

Mid-Hudson: Delaware, Dutchess, Orange, Putnam, Sullivan and Ulster.

Albany: Albany, Clinton, Columbia, Essex, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington.

Syracuse: Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Steuben, Tioga and Tompkins.

Buffalo: Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming.

Utica/ Watertown: Chenango, Franklin, Hamilton, Herkimer, Jefferson, Lewis, Madison, Oneida, Oswego, Otsego and St. Lawrence.

Rochester: Livingston, Monroe, Ontario, Seneca, Wayne and Yates.

Applicants must be residents of New York State to be eligible for coverage under one of these plans.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. The deductible and coinsurance amounts shown in the plan benefit charts on pages 4 to 11 of this document are the amounts effective for calendar year 2019.

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 EmblemHealth, P.O. Box 2820, New York, NY 10016-2820. 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.

EmblemHealth is 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

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

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* Semi-private room and board, general nursing and miscellaneous services and supplies First 60 days	All but $1,364	$0	$1,364 (Part A deductible)
61st through 90th day	All but $341 a day	$341 a day	$0
91st 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 (lifetime)	$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 $170.50 a day	$0	Up to $170.50 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 coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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 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 & 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%	Generally 20%	$0
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
PARTS A & B			
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	$0	$185 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

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* Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,364	$1,364 (Part A deductible)	$0
61st through 90th day	All but $341 a day	$341 a day	$0
91st 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 (lifetime)	$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 $170.50 a day	$0	Up to $170.50 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 coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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 OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical & 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%	Generally 20%	$0
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
PARTS A & B			
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	$0	$185 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN C

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* Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,364	$1,364 (Part A deductible)	$0
61st through 90th day	All but $341 a day	$341 a day	$0
91st 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 (lifetime)	$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 $170.50 a day	Up to $170.50 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 coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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 & speech therapy, diagnostic tests, durable medical equipment First $185 of Medicare-approved amounts*	$0	$185 (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 $185 of Medicare-approved amounts*	$0	$185 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
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
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

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* Semi-private room and board, general nursing and miscellaneous services and supplies First 60 days	All but $1,364	$1,364 (Part A deductible)	$0
61st through 90th day	All but $341 a day	$341 a day	$0
91st 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 (lifetime)	$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 $170.50 a day	Up to $170.50 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 coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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 & speech therapy, diagnostic tests, durable medical equipment First $185 of Medicare-approved amounts*	$0	$185 (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 $185 of Medicare-approved amounts*	$0	$185 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
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
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

HIGH DEDUCTIBLE 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.

**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year deductible of $2,300 in 2019. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $2,300 in 2019. 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 $2,300 DEDUCTIBLE IN 2019, * PLAN PAYS	IN ADDITION TO $2,300 DEDUCTIBLE IN 2019, ** YOU PAY
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,364	$1,364 (Part A deductible)	$0
61st through 90th day	All but $341 a day	$341 a day	$0
91st 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 (lifetime)	$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 $170.50 a day	Up to $170.50 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 coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,300 DEDUCTIBLE IN 2019, * PLAN PAYS	IN ADDITION TO $2,300 DEDUCTIBLE IN 2019, ** 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 & speech therapy, diagnostic tests, durable medical equipment First $185 of Medicare-approved amounts*	$0	$185 (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 $185 of Medicare-approved amounts*	$0	$185 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
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
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

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For additional information, call **1-866-287-7151**, 8 am to 8 pm, seven days a week (excluding major holidays). If you have a hearing or speech impairment and use a TTY/TDD, please call **711** 8 am to 8 pm, seven days a week (excluding major holidays). Or visit us on the web at **emblemhealth.com/Our-Plans/Medicare-Supplemental-Plans**.

EmblemHealth Medicare supplement plans are **underwritten by Group Health incorporated ("GHI")**, an Emblem Health company. Coverage is subject to all terms, conditions, limitations and exclusions set forth in the applicable EmblemHealth Medicare Supplement plan contract.

Special Notice
Each EmblemHealth Medicare Supplement Insurance plan meets the minimum standards for Medicare Supplement Insurance as defined by the New York State Department of Financial Services. The expected benefit ratio for each of these policies is 90 percent. This ratio is the portion of future premiums which GHI expects to return as benefits when averaged over all people with the policy.

IMPORTANT NOTICE — A CONSUMER'S GUIDE TO HEALTH INSURANCE FOR PEOPLE ELIGIBLE FOR MEDICARE MAY BE OBTAINED FROM YOUR LOCAL SOCIAL SECURITY OFFICE OR FROM EMBLEMHEALTH.

This advertisement is not connected with or endorsed by the U.S. Government or the federal Medicare program. This is a solicitation of insurance. A licensed insurance agent/producer may contact you.

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