NEA Group Medicare Supplement: PLAN OPTION ME9

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 ME9 PAYS	YOU PAY
HOSPITALIZATION *			
Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days:	All but $1,600	$1,600 (Part A Deductible)	$0†
61st through 90th day:	All but $400 a day	$400 a day	$0†
91st day and after:			
While using 60 lifetime reserve days:	All but $800 a day	$800 a day	$0†
Once lifetime reserve days are used:		100% of Medicare-Eligible Expenses	
Additional 365 days:	$0		$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 $200 a day	$0	Up to $200 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 requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare coinsurance or copayment	$0†

† "0" indicates your responsibility for covered charges. You will be required to pay any non-covered charges.

NEA Group Medicare Supplement: PLAN OPTION ME9 CONTINUED

Medicare Part B – Medical Services Per Calendar Year*

*Once you have been billed $226 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 ME9 PAYS	YOU PAY
MEDICAL EXPENSES *			
In or out of the hospital and outpatient hospital treatment, such as physician services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First $226 of Medicare-approved amounts*:	$0	$0	$226 (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 $226 of Medicare-approved amounts*:	$0	$0	$226 (Part B Deductible)
Remainder of Medicare-approved amounts:	80%	20%	$0†
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services:	100%	$0	$0†

Medicare Parts A & B

HOME HEALTH CARE *			
Medicare-approved services:			
Medically necessary skilled care services and medical supplies:	100%	$0	$0†
Durable medical equipment:			
First $226 of Medicare-approved amounts*:	$0	$0	$226 (Part B Deductible)
Remainder of Medicare-approved amounts:	80%	20%	$0†

† "0" indicates your responsibility for covered charges. You will be required to pay any non-covered charges.

Other Benefits – Not Covered By Medicare

FOREIGN TRAVEL			
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	$0	Balance