NEA Group Medicare Supplement: PLAN OPTION MG4

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 MG4 PAYS	YOU PAY
HOSPITALIZATION *			
Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days:	All but $1,632	$0	$1,632 (Part A Deductible)
61st through 90th day:	All but $408 per day	$408 per day	$0†
91st day thru 150th day: (Lifetime reserve):	All but $816 per day	$816 per day	$0†
Additional 365 days (151st to 515th day):	$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 $204 per day	$0	$204 per day
101st day thru 120th day:	$0	$0	All costs
121st 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.	100% of Medicare copayment/coinsurance	$0†

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

NEA Group Medicare Supplement: PLAN OPTION MG4 CONTINUED

Medicare Part B – Medical Services Per Calendar Year*

*Once you have been billed $240 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 MG4 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 $240 of Medicare-approved amounts* (the Part B Deductible):	$0	$0	$240 (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 $240 of Medicare-approved amounts*:	$0	$0	$240 (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 $240 of Medicare-approved amounts*:	$0	$0	$240 (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			
IMMUNIZATIONS - Not covered under Medicare Part D:	$0	100%	$0
PREVENTIVE MEDICAL CARE - Not covered under Medicare:	$0	$0	All costs
FOREIGN TRAVEL - Emergency:	$0	80%	20%
FOREIGN TRAVEL - Hospital and medical expenses and supplies:	$0	$0	All costs