# NEA Group Medicare Supplement: PLAN OPTION MG6

## 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 MG6 PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION *** | | | |
| Semi-private room and board, general nursing and miscellaneous services and supplies: | | | |
| First 60 days: | All but $1,632 | $1,632 (Part A Deductible) Rider UGRBMCAR | $0† |
| 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 | $204 per day | $0† |
| 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 MG6 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 MG6 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 | 100% Rider UGRBRMN2R | $0† |
| **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 |