

# Understanding Medicare and Medicare Supplement Insurance

## Program Option B

### NEA Medicare Supplement Program

#### 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  | Program Option B Pays              | You Pay              |
|--|--|------------------------------------|----------------------|
| <b>HOSPITALIZATION*</b>  |  |                                    |                      |
| Semi-private room and board, general nursing and miscellaneous services and supplies:  |  |                                    |                      |
| First 60 days:   | All but \$1,100  | \$1,100<br>(Part A Deductible)     | \$0†                 |
| 61 <sup>st</sup> through 90 <sup>th</sup> day:   | All but \$275 a day  | \$275 a day                        | \$0†                 |
| 91 <sup>st</sup> day and after:<br>While using 60 lifetime reserve days:   | All but \$550 a day  | \$550 a day                        | \$0†                 |
| Once lifetime reserve days are used:<br>Additional 365 days:   | \$0  | 100% of Medicare Eligible Expenses | \$0†                 |
| Beyond the additional 365 days:  | \$0  | \$0                                | All costs            |
| <b>SKILLED NURSING FACILITY CARE*</b>  |  |                                    |                      |
| 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 <sup>st</sup> day through 100 <sup>th</sup> day:  | All but \$137.50 a day   | \$0                                | Up to \$137.50 a day |
| 101 <sup>st</sup> day and after:   | \$0  | \$0                                | All costs            |
| <b>BLOOD</b>   |  |                                    |                      |
| First 3 pints:   | \$0  | 3 pints                            | \$0†                 |
| Additional amounts:  | 100%   | \$0                                | \$0†                 |
| <b>HOSPICE CARE</b>  |  |                                    |                      |
| Available as long as your doctor certifies you are terminally ill and you elect to receive these services.   | Generally, most Medicare eligible expenses for out-patient drugs and inpatient respite care. | \$0                                | Balance              |

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

## Understanding Medicare and Medicare Supplement Insurance

### NEA Medicare Supplement Program Part B – Medical Services Per Calendar Year\*

\*Once you have been billed \$155 of Medicare approved amounts for covered services, your Medicare part B Deductible will have been met for the calendar year.

| Services   | Medicare Pays                                      | Program Option B Pays                  | You Pay                                   |
|--|--|--|---|
| <b>MEDICAL EXPENSES*</b>   |  |  |   |
| 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 \$155 of Medicare Approved Amounts*:   | \$0  | \$0                                    | \$155<br>(Part B Deductible)              |
| Preventive Benefits for Medicare covered services:   | Generally 75% or more of Medicare approved amounts | Remainder of Medicare approved amounts | All costs above Medicare approved amounts |
| Remainder of Medicare approved amounts:  | Generally 80%                                      | Generally 20%                          | \$0†                                      |
| <b>PART B EXCESS CHARGES</b>   |  |  |   |
| (Above Medicare approved amounts)  | \$0  | \$0                                    | All Costs                                 |
| <b>BLOOD</b>   |  |  |   |
| First 3 pints:   | \$0  | All costs                              | \$0†                                      |
| Next \$155 of Medicare approved amounts+:  | \$0  | \$0                                    | \$155<br>(Part B Deductible)              |
| Remainder of Medicare approved amounts:  | 80%  | 20%                                    | \$0†                                      |
| <b>CLINICAL LABORATORY SERVICES</b>  |  |  |   |
| Tests for diagnostic services  | 100%   | \$0                                    | \$0†                                      |

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## Medicare Parts A & B

### HOSPITALIZATION\*

|  |      |     |                              |
|--|------|-----|------------------------------|
| Medicare approved services:  |      |     |                              |
| Medically necessary skilled care services and medical supplies:          | 100% | \$0 | \$0†                         |
| Durable medical equipment:<br>First \$155 of Medicare approved amounts*: | \$0  | \$0 | \$155<br>(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.