NEA® Retiree Health Program: PLAN OPTION K

Medicare Part A – Hospital Services Per Benefit Period*

You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $5,240 each calendar year. The amounts that count toward your annual limit are noted with two asterisks (**) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying the difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

*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 K PAYS	YOU PAY
HOSPITALIZATION *			
Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days:	All but $1,340	$670 (50% of Part A Deductible)	$670 (50% of Part A Deductible)**
61st through 90th day:	All but $335 a day	$335 a day	$0†
91st day and after:			
While using 60 lifetime reserve days:	All but $670 a day	$670 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 day through 100th day:	All but $167.50 a day	Up to $83.75 a day (50% of Part A coinsurance)	Up to $83.75 a day** (50% of Part A coinsurance)
101st day and after:	$0	$0	$0
BLOOD			
First 3 pints:	$0	50%	50%**
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.	50% of coinsurance or copayments	50% of coinsurance or copayments**

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

NEA Retiree Health Program: PLAN OPTION K CONTINUED

Medicare Part B – Medical Services Per Calendar Year*

*Once you have been billed $183 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 K 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 and speech therapy, diagnostic tests, durable medical equipment:			
First $183 of Medicare-approved amounts*:	$0	$0	$183 (Part B Deductible)*
Preventive Benefits for Medicare covered services:	Generally 80% of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-approved amounts:	Generally 80%	Generally 10%	Generally 10%**
PART B EXCESS CHARGES			
Above Medicare-approved amounts:	$0	100%	All costs (and they do not count towards annual out-of pocket limit of $5,240)**
BLOOD*			
First 3 pints:	$0	50%	50%
Next $183 of Medicare-approved amounts*:	$0	$0†	$183 (Part B Deductible)*
Remainder of Medicare-approved amounts:	Generally 80%	Generally 10%	Generally 10%**
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 $183 of Medicare-approved amounts *:	$0	$0	$183 (Part B Deductible)*
Remainder of Medicare-approved amounts:	80%	10%	10%**

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

Plan Option K Certificateholders also receive access to Pharmaceutical, Dental, Chiropractic, Hearing and Vision discounts – see "EXTRA FEATURES" for details.

** This plan limits your annual out-of-pocket payments for Medicare approved amounts to $5,240 per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**