

NEA® Retiree Health Program: **PLAN OPTION A**

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 A PAYS	YOU PAY
HOSPITALIZATION *			
Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days:	All but \$1,216	\$0	\$1,216 (Part A Deductible)
61st through 90th day:	All but \$304 a day	\$304 a day	\$0 [†]
91st day and after:			
While using 60 lifetime reserve days:	All but \$608 a day	\$608 a day	\$0 [†]
Once lifetime reserve days are used:			
Additional 365 days:	\$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 \$152 a day	\$0	Up to \$152 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 Retiree Health Program: **PLAN OPTION A** CONTINUED

Medicare Part B – Medical Services Per Calendar Year*

*Once you have been billed \$147 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 A 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 \$147 of Medicare-approved amounts*:	\$0	\$0	\$147 (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 \$147 of Medicare-approved amounts*:	\$0	\$0	\$147 (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 \$147 of Medicare-approved amounts *:	\$0	\$0	\$147 (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.