AARP Plan K

Medicare Part A & B

Plan K
Medicare Part A
Hospital Services - Per Benefit Period[1]

Services	Medicare Pays	Plan K Pays	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $592	$592 (50% of Part A Deductible)	$592 (50% of Part A Deductible)◊
61st thru 90th day	All but $296/day	$296/day	$0
91st day and after: • While using 60 lifetime reserve days • Once lifetime reserve days are used:	All but $592/day	$592/day	$0
- Additional 365 days	$0	100% of Medicare-eligible expenses	$0[2]
- Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $148/day	Up to $74/day	Up to $74/day◊
101st day and after	$0	$0	All costs
Blood			
First three pints	$0	50%	50%◊
Additional Amounts	100%	$0	$0
Hospice Care			
Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	50% of copayment/ coinsurance	50% of Medicare copayment/coinsurance◊

[1] A benefit period begins on the first day you receive service as a hospital inpatient, and ends after you have been discharged and received no skilled care in any other facility for 60 consecutive days.

[2] **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

◊ You will pay half of the cost sharing of some covered services until you reach the annual out-of-pocket limit of $4,800 each calendar year. The amounts that count toward your annual limit are noted with diamonds(◊) in the chart above. Once you reach the annual limit, the plan pays 100 percent of the Medicare copayment and Coinsurance fees for the remainder of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges"); you will be responsible for paying the difference of the amount charged by your provider and the amount paid by Medicare for the item or service.

Plan K
Medicare Part B
Medical Services - Per Calendar Year

Services	Medicare Pays	Plan K Pays	You Pay
Medical Expenses **Includes Treatment 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; and durable medical equipment			
First $147 of Medicare-approved amounts[5]	$0	$0	$147 (Part B Deductible) [5◊]
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
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $4,800)[4]
Blood			
First three pints	$0	50%	50%◊
Next $147 of Medicare-approved amounts[3]	$0	$0	$147 (Part B Deductible)[5◊]
Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10%◊
Clinical Laboratory Services			
Tests for diagnostic services	100%	$0	$0

Plan K
Medicare Parts A and B

Services	Medicare Pays	Plan K Pays	You Pay
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[6]	$0	$0	$147 (Part B Deductible)◊
Remainder of Medicare-approved amounts	80%	10%	10%◊

[4] This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $4,800 per calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges"); you will be responsible for paying the difference of the amount charged by your provider and the amount paid by Medicare for the item or service.

[5] Once you have been billed $147 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

[6] Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

◊ You will pay half of the cost sharing of some covered services until you reach the annual out-of-pocket limit of $4,800 each calendar year. The amounts that count toward your annual limit are noted with diamonds(◊) in the chart above. Once you reach the annual limit, the plan pays 100 percent of the Medicare copayment and Coinsurance fees for the remainder of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges"); you will be responsible for paying the difference of the amount charged by your provider and the amount paid by Medicare for the item or service.