



Medicare Supplement (Medigap) Plan K Outline of Coverage - 2018

Call Today! • 844-349-6581
Info@AmeriLifeDirect.com

Plan K

Medicare Part A (Hospital Services) - Per Benefit Period (60 Days)*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
Hospitalization: Semi-Private Room & Board, general nursing and miscellaneous services & supplies			
Days 1-60	All but \$1,340	\$670 (50% of Medicare Part A deductible)	\$670 (50% of Medicare Part A deductible)**
Days 61-90	All but \$335	\$335/day	\$0
Days 91 & after (while using 60 lifetime reserve days)	All but \$670/day	\$670/day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
Beyond 365 additional days	\$0	\$0	All Costs
Skilled Nursing Facility Care*: You must meet requirements, including having been in hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
Days 1-20	All Approved Amounts	\$0	\$0
Days 21-100	All but \$167.50/day	Up to \$83.75/day	Up to \$83.75/day***
Days 101 & after	\$0	\$0	All Costs

*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.

**You will pay 50% of the cost on some of the covered services until you reach the annual out-of-pocket limit of \$5,120 each calendar year. However, this limit does NOT include charges from your provider that exceed the Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying the difference in the amount charges by your provider and the amount paid by Medicare for the item or service.

***This amount counts towards your annual out-of-pocket limit. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year.

****NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the 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.



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Blood			
First 3 pints	\$0	50%	50%
Additional Amounts	100%	\$0	\$0
Hospice Care: You must meet Medicare's requirements, including a doctor's certification of terminal illness			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	50% Medicare copayment/coinsurance	50% Medicare copayment/coinsurance

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****NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the 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.



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Medicare Part B (Physician Services) – Per Calendar Year

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
Medical Expenses: In or out of the hospital & outpatient hospital treatment. Such as physician services, inpatient & outpatient medical and surgical services/supplies, physical/speech therapy, durable medical equipment			
First \$183 of Medicare Approved Amounts*	\$0	\$0	\$183 (Part B deductible)*
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10%*
Part B Excess Charges			
Above Medicare Approved Amounts	\$0	\$0	All Costs. These costs do NOT count toward your annual out of pocket.
Blood			
First 3 pints	\$0	50%	50%*
Next \$183 of Medicare Approved Amounts*	\$0	\$0	\$183 (Part B deductible)**
Remainder of Medicare Approved Amounts	80%	10%	Generally 10%

*You will pay 50% of the cost on some of the covered services until you reach the annual out-of-pocket limit of \$5,120 each calendar year. However, this limit does NOT include charges from your provider that exceed the Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying the difference in the amount charges by your provider and the amount paid by Medicare for the item or service.

**This amount will count towards your annual out-of-pocket limit. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year.

***Once you have been billed \$183 (in 2018) of Medicare-approved amounts for covered services (which are not noted with an asterisk), your Part B deductible will have been met for the calendar year.



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Medicare Part B (Physician Services) – Per Calendar Year

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
Clinical Laboratory Services			
Test for Diagnostic Services	100%	\$0	\$0
Home Health Care- Medicare Approved Services			
Medically necessary skilled care services & 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

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**This amount will count towards your annual out-of-pocket limit. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year.

***Once you have been billed \$183 (in 2018) of Medicare-approved amounts for covered services (which are not noted with an asterisk), your Part B deductible will have been met for the calendar year.