ADOPTED REGULATION OF THE

COMMISSIONER OF INSURANCE

LCB File No. R075-02

Effective September 20, 2002

EXPLANATION – Matter in ***italics*** is new; matter in brackets ~~[omitted material]~~ is material to be omitted.

AUTHORITY: §§1-14, NRS 679B.130 and 687B.430.

Section 1. Chapter 687B of NAC is hereby amended by adding thereto a new section to read as follows:

"PACE program" means the program of all-inclusive care for the elderly established pursuant to section 1894 of the Social Security Act, 42 U.S.C. § 1395eee.

Sec. 2. NAC 687B.200 is hereby amended to read as follows:

687B.200 As used in NAC 687B.200 to 687B.330, inclusive, ***and section 1 of this regulation,*** unless the context otherwise requires, the words and terms defined in NAC 687B.201 to 687B.2045, inclusive, ***and section 1 of this regulation*** have the meanings ascribed to them in those sections.

Sec. 3. NAC 687B.2034 is hereby amended to read as follows:

687B.2034 "Medicare + Choice plan" means a plan of ~~[health insurance established by the program set forth in sections 1851 to 1859, inclusive, of the Social Security Act, 42 U.S.C. §§ 1395w-21 to -28, inclusive.]~~ ***coverage for health benefits under Medicare Part C, as defined in 42 U.S.C. §§ 1395w-28(b)(1), and includes:***

1. Coordinated care plans that provide health care services, including, without limitation:

(a) Health maintenance organization plans, with or without a point-of-service provider;

(b) Plans offered by provider-sponsored organizations; and

(c) Preferred provider organization plans;

2. Medical savings account plans that are coupled with a contribution into Medicare + Choice medical savings accounts; and

3. Medicare + Choice private fee-for-service plans.

Sec. 4. NAC 687B.206 is hereby amended to read as follows:

687B.206 1. A person is eligible for a policy to supplement Medicare that is offered to new enrollees or for a certificate that is offered to new enrollees if he provides evidence that he disenrolled within the previous 63 days from:

(a) An employee welfare benefit plan that:

(1) Provided health benefits to supplement the benefits provided under Medicare; and

(2) Discontinued providing substantially all such supplemental health benefits to the person.

(b) An employee welfare benefit plan that:

(1) Provided health benefits that were primary to the benefits provided under Medicare; and

(2) Discontinued providing all such health benefits to the person because the employee welfare benefit plan was terminated or the person disenrolled from the employee welfare benefit plan.

(c) A Medicare + Choice plan offered by a Medicare + Choice organization pursuant to Medicare Part C, if the person was allowed to disenroll from the Medicare + Choice plan under any of the following circumstances:

(1) The certification of the ~~[Medicare + Choice]~~ organization or the ~~[Medicare + Choice plan was]~~ ***plan has been*** terminated ***,*** or the ~~[Medicare + Choice organization discontinued offering the Medicare + Choice plan in the area where the person resided.]~~ ***organization or plan has notified the person of an impending termination of its certification.***

(2) ***The organization has terminated or otherwise discontinued providing the plan in the area in which the person resides, or has notified the person of an impending termination or discontinuance of the plan.***

(3) The person was no longer eligible to elect a Medicare + Choice plan because:

(I) His residence changed;

(II) The Medicare + Choice plan was terminated with respect to all persons in the area where the person resided; or

(III) Other circumstances as specified by the Secretary of Health and Human Services changed. Those circumstances do not include terminating the election of the person pursuant to section 1851(g)(3)(B)(i) or (ii) of the Social Security Act, 42 U.S.C. § 1395w-21(g)(3)(B)(i) or (ii).

~~[(3)]~~ ***(4)*** The person demonstrated in accordance with guidelines established by the Secretary of Health and Human Services that:

(I) The Medicare + Choice organization offering the Medicare + Choice plan substantially violated a material provision of the contract of the Medicare + Choice organization under Medicare Part C with respect to the person, including, without limitation, failing to provide to an enrollee on a timely basis medically necessary care for which benefits are available under the Medicare + Choice plan or failing to provide such care in accordance with applicable quality standards; or

(II) The Medicare + Choice organization, agent or other person acting on behalf of the Medicare + Choice organization made a material misrepresentation of the provisions of the Medicare + Choice plan.

~~[(4)]~~ *(5)* The person met such other exceptional condition as provided by the Secretary of Health and Human Services.

(d) ***The PACE program if the person is 65 years of age or older and there are circumstances similar to those described in paragraph (c) that would permit discontinuance of the person's enrollment with the provider if he were enrolled in a Medicare + Choice plan.***

(e) If the person disenrolled pursuant to the same circumstances that are required to disenroll from a plan pursuant to paragraph (c), any plan offered by:

(1) An eligible organization that had a risk-sharing contract or a reasonable cost reimbursement contract with the Secretary of Health and Human Services pursuant to section 1876 of the Social Security Act, 42 U.S.C. § 1395mm;

(2) For periods before April 1, 1999, an insurer that operated pursuant to the authority of a demonstration project;

(3) An insurer that had an agreement to provide medical and other health services on a prepaid basis pursuant to section 1833(a)(1)(A) of the Social Security Act, 42 U.S.C. § 1395l(a)(1)(A); or

(4) A Medicare select issuer that had a Medicare select policy.

~~[(e)]~~ *(f)* A policy to supplement Medicare or a certificate, if the person disenrolled from that policy or certificate because:

(1) The insurer filed a voluntary petition in bankruptcy or had an involuntary petition in bankruptcy filed against it and the insurer ceased doing business in this state;

(2) The issuer was adjudicated insolvent by a court of competent jurisdiction in the state of domicile of the issuer;

(3) The insurer involuntarily terminated coverage or enrollment;

(4) The issuer of the policy or certificate substantially violated a material provision of the policy or certificate; or

(5) The issuer, an agent or other person acting on behalf of the issuer made a material misrepresentation of the provisions of the policy or certificate.

2. ***In lieu of using the date of termination of enrollment for purposes of this section, a person described in paragraph (c) or (d) of subsection 1 may substitute the date on which he was notified by the Medicare + Choice organization of the impending termination or discontinuance of the Medicare + Choice plan offered by the Medicare + Choice organization in the area in which the person resides, but only if the person disenrolls from the plan as a result of that notification. If a person makes the substitution provided in this subsection, the issuer shall accept the application of the person submitted before the date of termination or enrollment, but the coverage under this subsection must become effective only upon termination of coverage under the Medicare + Choice plan involved.***

3. A person who is eligible for a policy to supplement Medicare or a certificate pursuant to subsection 1 is entitled to obtain from any issuer a policy to supplement Medicare or a certificate that has a benefit plan that is designated as Standardized Benefit Plan A, B, C, F or High Deductible Benefit Plan F.

~~[3.]~~ ***4.*** As used in this section, "Medicare select policy" has the meaning ascribed to it in NAC 687B.348.

Sec. 5. NAC 687B.2062 is hereby amended to read as follows:

687B.2062 1. A person is eligible for a policy to supplement Medicare that is offered to new enrollees or for a certificate that is offered to new enrollees if he provides evidence that he:

(a) Disenrolled from such a policy or certificate;

(b) Subsequently enrolled for the first time in:

(1) A Medicare + Choice plan offered by a Medicare + Choice organization pursuant to Medicare Part C; [or]

(2) A plan offered by an eligible organization, insurer or a Medicare select issuer listed in paragraph [(d)] ***(e)*** of subsection 1 of NAC 687B.206; ***or***

(3) Any PACE program; and

(c) Disenrolled within the previous 63 days from the subsequent plan within 12 months after his enrollment as authorized pursuant to section 1851(e) of the Social Security Act, 42 U.S.C. § 1395w-21(e).

2. A person who is eligible for a policy to supplement Medicare or a certificate pursuant to subsection 1 is entitled to obtain a policy to supplement Medicare or a certificate with the same benefits as his original policy or certificate from the same issuer if the issuer offers the same policy or certificate or, if that policy or certificate is no longer offered, he is entitled to obtain from any issuer a policy to supplement Medicare or a certificate that has a benefit plan that is designated as Standardized Benefit Plan A, B, C, F or High Deductible Benefit Plan F.

Sec. 6. NAC 687B.2064 is hereby amended to read as follows:

687B.2064 1. A person is eligible for a policy to supplement Medicare that is offered to new enrollees or for a certificate that is offered to new enrollees if he provides evidence that he has disenrolled within the previous 63 days from a Medicare + Choice plan offered by a Medicare + Choice organization pursuant to Medicare Part C ***, or from a PACE program,*** if he:

(a) Enrolled in that plan ***or program*** during the first 6-month period during which he was both 65 years of age or older and was enrolled for benefits under Medicare Part B; and

(b) Disenrolled from the plan ***or program*** not later than 12 months after the effective date of enrollment.

2. A person who is eligible for a policy to supplement Medicare or a certificate pursuant to subsection 1 is entitled to obtain from any issuer any policy to supplement Medicare or certificate.

Sec. 7. NAC 687B.209 is hereby amended to read as follows:

687B.209 1. Any time a plan, certificate or policy to supplement Medicare is terminated or a person disenrolls from a plan, certificate [,] or policy to supplement Medicare, the issuer, insurer, Medicare + Choice organization, eligible organization or Medicare select issuer that offered the plan, certificate or policy shall provide written notification informing the person that:

(a) He may be entitled to obtain a certificate or a policy to supplement Medicare pursuant to NAC 687B.206, 687B.2062 or 687B.2064; and

(b) The issuer of such a certificate or policy must comply with the provisions of NAC 687B.2068.

2. If the plan, certificate or policy was terminated, the notification required pursuant to subsection 1 must be provided with the notification of termination. If the person disenrolled from the plan, certificate or policy, the notification required pursuant to subsection 1 must be provided within 10 working days after the issuer, insurer, Medicare +Choice organization, eligible organization or Medicare select issuer received notification of the disenrollment.

3. As used in this section, “plan” means:

(a) A Medicare + Choice plan;

(b) An employee welfare benefit plan; or

(c) A plan offered by an eligible organization, insurer or a Medicare select issuer listed in paragraph [(d)] *(e)* of subsection 1 of NAC 687B.206.

Sec. 8. NAC 687B.225 is hereby amended to read as follows:

687B.225 1. A policy of insurance or subscriber contract must not be advertised, solicited or issued for delivery in this state as a policy or certificate to supplement Medicare before July 16, 1992, if it fails to meet the standards established by this section. These are minimum standards and do not preclude the inclusion of other provisions or benefits that are not inconsistent with these standards.

2. A policy to supplement Medicare or a certificate ***issued for delivery in this state before July 16, 1992,*** must not:

(a) Deny a claim for losses incurred more than 6 months after the effective date of coverage for a preexisting condition.

(b) Define a preexisting condition more restrictively than as a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.

(c) Indemnify against any loss resulting from sickness on a different basis than for a loss resulting from an accident.

3. A policy to supplement Medicare or a certificate must provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

4. A "noncancellable," "guaranteed renewable" or "noncancellable and guaranteed renewable" policy must not:

(a) Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premiums; or

(b) Be canceled or denied renewal by the insurer solely on the grounds of deterioration of health.

5. Termination of a policy to supplement Medicare or ***of*** a certificate must be without prejudice to any continuous loss that commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits.

6. A policy to supplement Medicare that is subject to the minimum standards adopted pursuant to the Medicare Catastrophic Coverage Act of 1988 must provide at least the following benefits:

(a) Coverage of Medicare Part A eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period.

(b) Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount.

(c) Coverage of Medicare Part A eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days.

(d) Upon exhaustion of all Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 90 percent of all Medicare Part A eligible expenses for hospitalization

that are not covered by Medicare, subject to a lifetime maximum benefit of an additional 365 days.

(e) Coverage under Medicare Part A for the reasonable cost of the first 3 pints of blood, or an equivalent quantity of packed red blood cells, as defined by federal regulations, unless replaced in accordance with federal regulations or already paid for pursuant to Part B.

(f) Coverage for the coinsurance amount ***, or, for services from a hospital outpatient department paid under a prospective payment system, the copayment amount,*** of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount that is equal to the Medicare Part B deductible of [~~$75.~~] ***$100.***

(g) Coverage under Medicare Part B for the reasonable cost of the first 3 pints of blood, or equivalent quantities of packed red blood cells, as defined by federal regulations, unless replaced in accordance with federal regulations or already paid for pursuant to Part A, subject to the Medicare deductible amount.

7. For the purposes of this section:

(a) "Medicare eligible expenses" means expenses for health care of the kind covered by Medicare, to the extent recognized as reasonable by Medicare. Payment of benefits by an insurer for such expenses may be conditioned upon the same or less restrictive conditions of payment, including determinations of medical necessity, as are applicable to Medicare claims.

(b) "Policy to supplement Medicare" means a group or individual policy of accident and sickness insurance, or a subscriber contract of one or more hospital and medical service associations or health maintenance organizations, that is advertised, marketed or designed

primarily as a supplement to the reimbursement provided under Medicare for the hospital, medical or surgical expenses of one or more persons eligible for Medicare by reason of age.

Sec. 9. NAC 687B.226 is hereby amended to read as follows:

687B.226 1. A policy or certificate must not be advertised, solicited, originally delivered or issued for delivery, or renewed in this state as a policy or certificate to supplement Medicare on or after July 16, 1992, and before July 30, 1992, if it fails to meet or exceed the minimum standards established by this section. These standards do not preclude the inclusion of other provisions or benefits that are not inconsistent with these standards.

2. A policy to supplement Medicare or a certificate ***originally delivered or issued for delivery, or renewed, in this state on or after July 16, 1992, and before July 30, 1992,*** must not:

(a) Exclude or limit benefits for losses incurred more than 6 months after the effective date of coverage because of a preexisting condition.

(b) Define a preexisting condition more restrictively than as a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.

(c) Indemnify against any loss resulting from sickness on a different basis than for a loss resulting from an accident.

3. A policy to supplement Medicare or a certificate must provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

4. A "noncancellable," "guaranteed renewable" or "noncancellable and guaranteed renewable" policy must not:

(a) Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premiums; or

(b) Be canceled or denied renewal by the insurer solely on the grounds of deterioration of health.

5. Except as otherwise authorized by the commissioner, an issuer shall not cancel or refuse to renew a policy to supplement Medicare or a certificate for any other reason than the nonpayment of premiums or for a material misrepresentation.

6. If a group policy to supplement Medicare or a certificate is terminated by the group policyholder and is not replaced as provided in subsection 8, the issuer shall offer to each certificate holder:

(a) An individual policy to supplement Medicare currently offered by the issuer that provides comparable benefits to those contained in the terminated policy; or

(b) An individual policy to supplement Medicare that provides only those benefits as are required by NAC 687B.290.

7. If a certificate holder is provided coverage under a group policy to supplement Medicare or a certificate and he terminates his membership in the group, the issuer shall:

(a) Offer the certificate holder an individual policy to supplement Medicare pursuant to subsection 6; or

(b) At the request of the group policyholder, continue coverage for the certificate holder under the group policy to supplement Medicare.

8. If a group policy to supplement Medicare or a certificate is replaced by another group policy to supplement Medicare or another certificate which is purchased by the same person, the

issuer of the replacement policy or certificate shall offer coverage to all persons who are covered under the policy or certificate that is being replaced on the date it is terminated. The replacement policy or certificate may not provide for the exclusion of coverage for preexisting conditions that were covered under the policy or certificate that is being replaced.

9. Termination of a policy to supplement Medicare or ***of*** a certificate must be without prejudice to any continuous loss that commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits.

10. A policy to supplement Medicare that is subject to the minimum standards must provide at least the following benefits:

(a) Coverage of Medicare Part A eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period.

(b) Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount.

(c) Coverage of Medicare Part A eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days.

(d) Upon exhaustion of all Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 90 percent of all Medicare Part A eligible expenses for hospitalization that are not covered by Medicare, subject to a lifetime maximum benefit of an additional 365 days.

(e) Coverage under Medicare Part A for the reasonable cost of the first 3 pints of blood, or an equivalent quantity of packed red blood cells, as defined by federal regulations, unless replaced in accordance with federal regulations or already paid for pursuant to Part B.

(f) Coverage for the coinsurance amount ***, or, for services from a hospital outpatient department paid under a prospective payment system, the copayment amount,*** of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount that is equal to the Medicare Part B deductible of $100. This coverage must include coverage for Medicare eligible expenses for drugs used by an outpatient for immune suppressive therapy.

(g) Coverage under Medicare Part B for the reasonable cost of the first 3 pints of blood, or equivalent quantities of packed red blood cells, as defined by federal regulations, unless replaced in accordance with federal regulations or already paid for pursuant to Part A, subject to the Medicare deductible amount.

Sec. 10. NAC 687B.227 is hereby amended to read as follows:

687B.227 1. A policy or certificate must not be advertised, solicited, originally delivered or issued for delivery, or renewed in this state as a policy or certificate to supplement Medicare on or after July 30, 1992, if it fails to comply with the requirements set forth in this section.

2. A policy to supplement Medicare or a certificate ***originally delivered or issued for delivery, or renewed, in this state on or after July 30, 1992,*** must not:

(a) Exclude or limit benefits for losses incurred more than 6 months after the effective date of coverage because of a preexisting condition.

(b) Define a preexisting condition more restrictively than as a condition for which medical advice was given or treatment recommended by or received from a physician during the 6 months immediately preceding the effective date of coverage.

(c) Indemnify against any loss resulting from sickness on a different basis than for a loss resulting from an accident.

3. A policy to supplement Medicare or a certificate must provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

4. A policy to supplement Medicare or a certificate must not provide for the termination of coverage of a spouse solely because of the occurrence of an event specified for the termination of coverage for the insured, other than the nonpayment of premiums.

5. A policy to supplement Medicare or a certificate must be guaranteed renewable. The issuer may not cancel or refuse to renew the policy or certificate solely because of the health of the insured or for any other reason than the nonpayment of premiums or for a material misrepresentation.

6. Termination of a policy to supplement Medicare or a certificate must be without prejudice to any continuous loss that commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, and limited to the duration of the policy benefit period, if any, or to the payment of the maximum benefits.

7. Benefits and premiums must be suspended at the request of the policyholder or certificate holder for the period, not to exceed 24 months, during which the holder has applied for and is

determined to be eligible for medical assistance under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 et seq., if the holder notifies the issuer of the policy or certificate within 90 days after the date he becomes eligible for such assistance.

8. If benefits and premiums are suspended pursuant to subsection 7 and the policyholder or certificate holder loses his eligibility for assistance under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 et seq., the policy to supplement Medicare or the certificate must be automatically reinstated effective as of the date the holder is no longer eligible for assistance if he:

(a) Gives notice of his loss of eligibility to the issuer within 90 days; and

(b) Pays the premium attributable to his period of eligibility.

9. ***Benefits and premiums must be suspended at the request of the policyholder or certificate holder for any period that may be provided by federal regulation, during which the holder is entitled to benefits under section 226(b) of the Social Security Act, 42 U.S.C. § 426, and is covered under a group health plan, as that term is defined in section 1862(b)(1)(A)(v) of the Social Security Act, 42 U.S.C. § 1395y(b)(1)(A)(v). If benefits and premiums are suspended pursuant to this subsection and the policyholder or certificate holder loses coverage under the group health plan, the policy to supplement Medicare or the certificate must be automatically reinstated effective as of the date of loss of coverage if the policyholder or certificate holder provides notice of loss of coverage within 90 days after the date of the loss.***

10. If a policy to supplement Medicare or a certificate is reinstated pursuant to subsection 8 ~~[:]~~ ***or 9:***

(a) A waiting period for the treatment of any preexisting condition must not be required;

(b) The coverage provided must be substantially equivalent to the coverage in effect before the benefits and premiums were suspended; and

(c) The terms for the classification of premiums must be at least as favorable to the policyholder or certificate holder as the terms in effect before the benefits and premiums were suspended.

Sec. 11. NAC 687B.240 is hereby amended to read as follows:

687B.240 1. Each policy to supplement Medicare or certificate must include a renewal or continuation provision. The language or specifications of the provision must be consistent with the type of contract issued. The provision must:

(a) Be captioned appropriately;

(b) Appear on the first page of the policy;

(c) Include any reservation by the issuer to change premiums; and

(d) Include any automatic increases in premiums at the time of renewal which are based on the age of the policyholder.

2. Except for riders or endorsements by which the issuer:

(a) Effectuates a request made in writing by the insured;

(b) Exercises a specifically reserved right under a policy to supplement Medicare; or

(c) Is required to reduce or eliminate benefits to avoid a duplication of benefits provided by Medicare,

FLUSH any rider or endorsement added to a policy to supplement Medicare after the date of its issue, or upon reinstatement or renewal, which reduces or eliminates benefits or coverage provided by the policy, requires a signed acceptance by the insured. After the date the policy or certificate is issued, any rider or endorsement that increases benefits or coverage with a concomitant increase

in premiums during the term of the policy must be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for such policies to supplement Medicare, or if the increased benefits or coverage are required by law. If an additional premium is charged for benefits provided in connection with riders or endorsements, that premium must be set forth in the policy.

3. A policy to supplement Medicare or a certificate must not provide for the payment of benefits based upon standards described as "usual and customary," "reasonable and customary" or words of similar import.

4. If a policy to supplement Medicare or a certificate contains any limitations with respect to preexisting conditions, those limitations must appear as a separate paragraph of the policy and must be labeled "limitations for preexisting conditions."

5. Each policy to supplement Medicare or certificate must contain a notice, prominently printed on its first page or attached to that page, stating in substance that the policyholder or certificate holder is entitled to return the policy or certificate within 30 days after its delivery and to have the premium refunded if, after examination of the policy or certificate, the policyholder or certificate holder is not satisfied for any reason.

6. An issuer of an accident or sickness policy or certificate providing hospital or medical expense coverage on an expense incurred or indemnity basis to a person eligible for Medicare shall provide to all applicants a guide which must be entitled ~~["Health Insurance for People with Medicare"]~~ ***"Guide to Health Insurance for People with Medicare"*** and which:

(a) Uses the language, format, type size, proportional spacing, bold type and line spacing developed jointly by the National Association of Insurance Commissioners and the ~~[Health Care Financing Administration;]~~ ***Centers for Medicare & Medicaid Services;*** and

(b) Is in not less than 12-point type.

FLUSH The [guide] ***Guide*** to buyers required by this subsection must be delivered whether or not the policy or certificate is advertised, solicited or issued as a policy or certificate to supplement Medicare. Except as otherwise provided in this subsection, delivery of the [guide] ***Guide*** must be made to the applicant at the time of application. An acknowledgment of receipt of the [guide] ***Guide*** must be obtained by the issuer. Direct response issuers shall deliver the [guide] ***Guide*** to the applicant upon request but not later than at the time the policy is delivered.

Sec. 12. NAC 687B.250 is hereby amended to read as follows:

687B.250 1. Each issuer shall provide an outline of coverage to each applicant at the time the application is presented to the applicant and, except in the case of a direct response policy, shall obtain an acknowledgment from the applicant that he has received the outline.

2. If an outline of coverage is provided at the time of application and the policy to supplement Medicare or certificate is issued on a basis that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered. The substitute outline must contain the following statement, in not less than 12-point type, immediately above the name of the company:

NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued.

3. The outline of coverage provided to the applicant must consist of:

(a) A cover page;

(b) Information regarding premiums;

(c) Disclosure pages; and

(d) Charts displaying the features of each benefit plan offered by the issuer as set forth in subsection 6.

4. Standardized Benefit Plans A through J, inclusive, and High Deductible Benefit Plans F and J, must be shown on the cover page and the plans offered by the issuer must be prominently identified.

5. Information regarding premiums for benefit plans to supplement Medicare offered by the issuer must be shown on the cover page or immediately following the cover page and must be prominently displayed. The premium and mode must be stated for all plans that are offered to the applicant. All possible premiums must be illustrated.

6. The outline of coverage must be printed in not less than 12-point type, using the following language and format:

(COMPANY NAME)

Outline of Medicare Supplement Coverage - Cover Page:

Benefit Plan(s)___~~[insert letter(s) of plan(s) being offered]~~

Medicare supplement insurance may be sold in only ten standard plans and two high deductible benefit plans. This chart shows the benefits included in each plan.

Every company must make available Plan "A."

BASIC BENEFITS: Included in All Plans.

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance ~~[(]~~ ***(generally*** 20% of Medicare-approved ~~[expenses).]~~ ***expenses) or, for services from a hospital outpatient department under a prospective payment system, applicable copayments.***

Blood: First three pints of blood each year.

A	B	C	D	E	F	High Deductible F*	G	H	I	J	High Deductible J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible	Part B Deductible				Part B Deductible	Part B Deductible

					Part B Excess (100%)	Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	At-Home Recovery
								Basic Drugs ($1,250 Limit)	Basic Drugs ($1,250 Limit)	Extended Drugs ($3,000 Limit)	Extended Drugs ($3,000 Limit)
				Preventive Care						Preventive Care	Preventive Care

* The High Deductible Benefit Plans F and J offer benefits similar to the benefits offered by the Standardized Benefit Plans F and J except that the high deductible benefit plans require a higher deductible. For the calendar ~~[years of 1998 and 1999,]~~ ***year 2002,*** the High Deductible Benefit Plans F and J require the insured to pay an annual deductible in the amount of ~~[$1,500,]~~ ***$1,620,*** and thereafter those plans require the insured to pay an annual deductible that is adjusted by the Commissioner in the manner set forth in subsection 2 of NAC 687B.311 ~~[.]~~ ***and subsection 2 of NAC 687B.319, as appropriate.*** Benefits for the High Deductible Benefit Plans F and J begin after the insured has paid the annual deductible for expenses that would ordinarily be paid by the plans, including, without limitation, the Medicare Part A deductible and the Medicare Part B deductible. The annual deductible must be paid in addition to the premium and in addition to any other deductibles relating to a specific benefit, including, without limitation, the deductible for prescription drugs ***, if applicable,*** and the deductible for emergency care received in a foreign country.

PREMIUM INFORMATION (Boldface type)

We (insert issuer's name) can only raise your premium if we raise the premium for all policies like yours in this state. (If the premium is based on the increasing age of the insured, include information specifying when premiums will change.)

DISCLOSURES (Boldface type)

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY
(Boldface type)

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy to understand all of the rights and duties of you and your insurance company.

RIGHT TO RETURN POLICY (Boldface type)

If you find that you are not satisfied with your policy, you may return it to (insert issuer's address). If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT (Boldface type)

If you are replacing another policy of health insurance, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE (Boldface type)

This policy may not cover all of your medical costs.

(For agents)

Neither (insert company's name) nor its agents are connected with Medicare.

(For direct response)

(Insert company's name) is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local social security office or consult ~~["The Medicare Handbook"]~~ ***"Medicare & You"*** for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

(Boldface type)

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. (If the policy or certificate is guaranteed issue, this paragraph need not appear.)

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

(Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, and the same uniform layout and format as shown in the charts set forth in this subsection. No more than four plans may be shown on one chart. An issuer may use additional designations for benefit plans on these charts as authorized by subsection 4 of NAC 687B.295.)

(Include an explanation of any innovative benefits on the cover page and in the chart, in the manner approved by the commissioner.)

PLAN 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 consecutive days.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61st thru 90th day 91st day and after: While using 60 lifetime reserve days Once lifetime reserve days are used: Additional 365 days Beyond the additional 365 days	All but ~~[$764]~~ ***$812*** All but ~~[$191]~~ ***$203*** a day All but ~~[$382]~~ ***$406*** a day $0 $0	$0 ~~[$191]~~ ***$203*** a day ~~[$382]~~ ***$406*** a day 100% of Medicare Eligible Expenses $0	~~[$764]~~ ***$812*** (Part A Deductible) $0 $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	All approved amounts	$0 $0	$0 Up to ~~[$95.50]~~

within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	All but [$95.50] *$101.50* a day $0	$0	*$101.50* a day All costs
BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	 All but very limited coinsurance for outpatient drugs and inpatient respite care	 $0	 Balance

PLAN A

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 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 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 $100 of Medicare-approved amounts* Remainder of Medicare-approved amounts Part B excess charges (above Medicare-approved amounts)	$0 80% $0	$0 20% $0	$100 (Part B Deductible) $0 All costs
BLOOD First 3 pints Next $100 of Medicare-approved amounts* Remainder of Medicare-approved amounts	$0 $0 80%	All costs $0 20%	$0 $100 (Part B Deductible) $0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment: First $100 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% $0 80%	$0 $0 20%	$0 $100 (Part B Deductible) $0

PLAN B

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 consecutive days.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61st thru 90th day 91st day and after: While using 60 lifetime reserve days Once lifetime reserve days are used: Additional 365 Beyond the additional 365 days	All but ~~[$764]~~ ***$812*** All but ~~[$191]~~ ***$203*** a day All but ~~[$382]~~ ***$406*** a day $0 $0	~~[$764]~~ ***$812*** (Part A Deductible) ~~[$191]~~ ***$203*** a day ~~[$382]~~ ***$406*** a day 100% of Medicare Eligible Expenses $0	$0 $0 $0 $0 All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for a least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:	All approved amounts All but ~~[$95.50]~~ ***$101.50*** a day	$0 $0 $0	$0 Up to ~~[$95.50]~~ ***$101.50*** a day All costs

First 20 days 21st thru 100th day 101st day and after	$0		
BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN B

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 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 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 $100 of Medicare-approved amounts* Remainder of Medicare-approved amounts Part B excess charges (above Medicare-approved amounts)	$0 80% $0	$0 20% $0	$100 (Part B Deductible) $0 All costs
BLOOD First 3 pints Next $100 of Medicare-approved amounts* Remainder of Medicare-approved amounts	$0 $0 80%	All costs $0 20%	$0 $100 (Part B Deductible) $0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment: First $100 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% $0 80%	$0 $0 20%	$0 $100 (Part B Deductible) $0

PLAN C

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 consecutive days.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61st thru 90th day 91st day and after: While using 60 lifetime reserve days Once lifetime reserve days are used: Additional 365 days Beyond the additional 365 days	All but ~~[$764]~~ ***$812*** All but ~~[$191]~~ ***$203*** a day All but ~~[$382]~~ ***$406*** a day $0 $0	~~[$764]~~ ***$812*** (Part A Deductible) ~~[$191]~~ ***$203*** a day ~~[$382]~~ ***$406*** a day 100% of Medicare Eligible Expenses $0	$0 $0 $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:	All approved amounts All but ~~[$95.50]~~ ***$101.50*** a day	$0 Up to ~~[$95.50]~~ ***$101.50*** a day $0	$0 $0 All costs

First 20 days 21st thru 100th day 101st day and after	$0		
BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN C

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 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 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 $100 of Medicare-approved amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare-approved amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment: First $100 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% $0 80%	$0 $100 (Part B Deductible) 20%	$0 $0 $0

PLAN C

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States: First $250 each calendar year Remainder of charges	$0 $0	$0 80% to a lifetime maximum benefit of $50,000	$250 20% and amounts over the $50,000 lifetime maximum

PLAN D

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 consecutive days.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61st thru 90th day 91st day and after: While using 60 lifetime reserve days Once lifetime reserve days are used: Additional 365 days Beyond the additional 365 days	All but ~~[$764]~~ ***$812*** All but ~~[$191]~~ ***$203*** a day All but ~~[$382]~~ ***$406*** a day $0 $0	~~[$764]~~ ***$812*** (Part A Deductible) ~~[$191]~~ ***$203*** a day ~~[$382]~~ ***$406*** a day 100% of Medicare Eligible Expenses $0	$0 $0 $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:	All approved amounts All but ~~[$95.50]~~ ***$101.50*** a day	$0 Up to ~~[$95.50]~~ ***$101.50*** a day $0	$0 $0 All costs

First 20 days 21st thru 100th day 101st day and after	$0		
 BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
 HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	 All but very limited coinsurance for outpatients drugs and inpatient respite care	 $0	 Balance

PLAN D

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 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 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 $100 of Medicare-approved amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare-approved amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	$100	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment: First $100 of Medicare-approved amounts* Remainder of Medicare-approved amounts	$100 $0 80%	$0 $0 20%	$0 $100 (Part B Deductible) $0

PLAN D

MEDICARE (PARTS A & B) - ~~[CONTINUED]~~ ***(CONTINUED)***

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - (cont'd) AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan:			
Benefit for each visit	$0	Actual charges to $40 a visit	Balance
Number of visits covered (must be received within 8 weeks of last Medicare-approved visit)	$0	Up to the number of Medicare-approved visits, not to exceed seven each week	
Calendar year maximum	$0	$1,600	

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States:			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN E

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 consecutive days.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61st thru 90th day 91st day and after: While using 60 lifetime reserve days Once lifetime reserve days are used: Additional 365 days Beyond the additional 365 days	All but [$764] ***$812*** All but [$191] ***$203*** a day All but [$382] ***$406*** a day $0 $0	[$764] ***$812*** (Part A Deductible) [$191] ***$203*** a day [$382] ***$406*** a day 100% of Medicare Eligible Expenses $0	$0 $0 $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:	All approved amounts All but [$95.50] ***$101.50*** a day	$0 Up to [$95.50] ***$101.50*** a day $0	$0 $0 All costs

First 20 days 21st thru 100th day 101st day and after	$0		
BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN E

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 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.

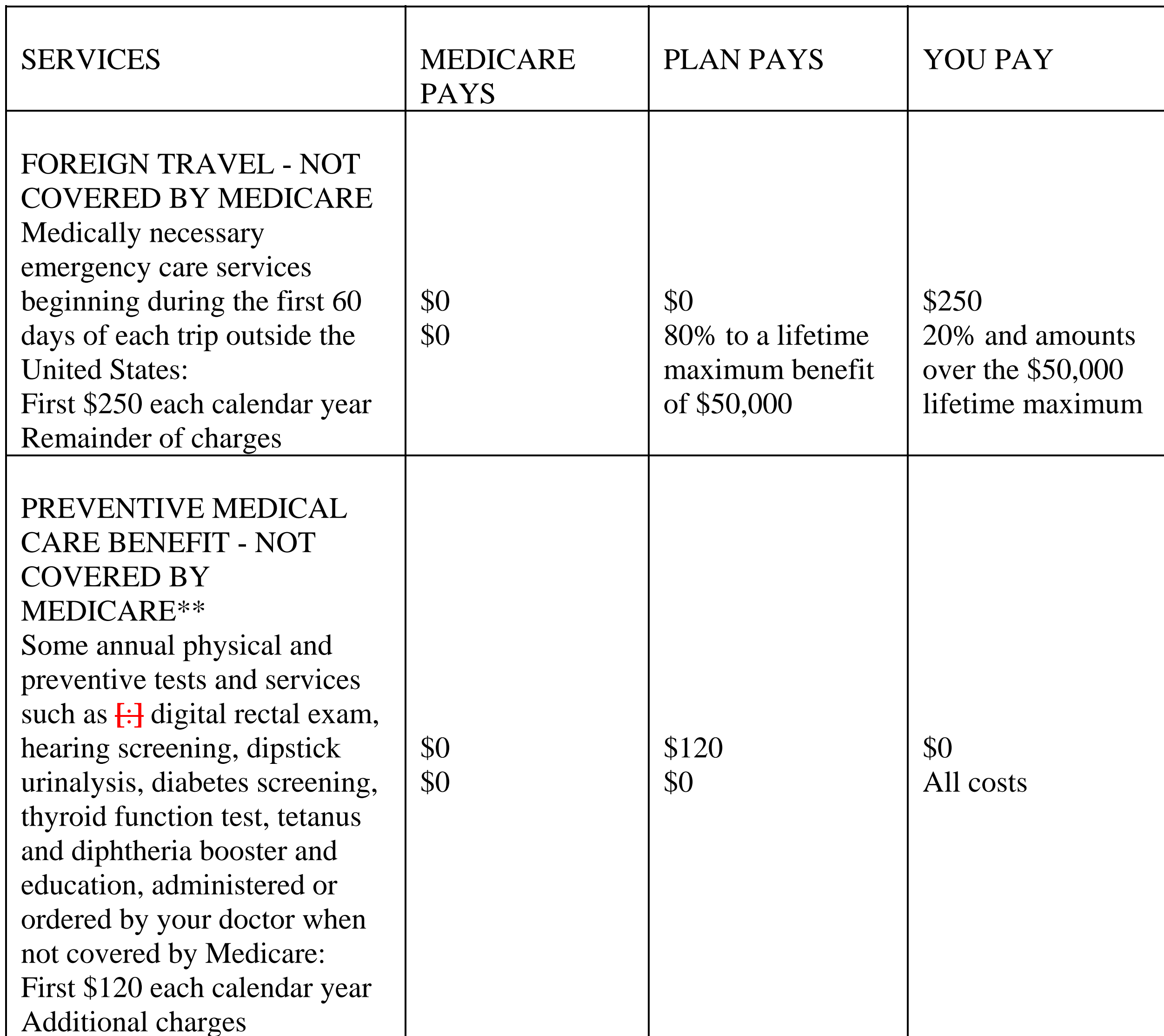
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: First $100 of Medicare-approved amounts* Remainder of Medicare-approved amounts Part B excess charges (above Medicare-approved amounts)	$0 80% $0	$0 20% $0	$100 (Part B Deductible) $0 All costs
BLOOD First 3 pints Next $100 of Medicare-approved amounts* Remainder of Medicare-approved amounts	$0 $0 80%	All costs $0 20%	$0 $100 (Part B Deductible) $0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment: First $100 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% $0 80%	$0 $0 20%	$0 $100 (Part B Deductible) $0

PLAN E

OTHER BENEFITS - NOT COVERED BY MEDICARE



SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States: First $250 each calendar year Remainder of charges	$0 $0	$0 80% to a lifetime maximum benefit of $50,000	$250 20% and amounts over the $50,000 lifetime maximum
PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE** Some annual physical and preventive tests and services such as [:] digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare: First $120 each calendar year Additional charges	$0 $0	$120 $0	$0 All costs

** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the “Guide to Health Insurance for People with Medicare” which must be provided by an issuer to an applicant pursuant to NAC 687B.240. For help in

understanding your health insurance, you may contact the Commissioner of Insurance or the Nevada ~~[Medicare Information, Counseling and Assistance Program]~~ ***State Health Insurance Advisory Program (SHIP)*** of the Aging Services Division of the Department of Human Resources.

PLAN F

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 consecutive days.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61st thru 90th day 91st day and after: While using 60 lifetime reserve days Once lifetime reserve days are used: Additional 365 days Beyond the additional 365 days	All but ~~[$764]~~ ***$812*** All but ~~[$191]~~ ***$203*** a day All but ~~[$382]~~ ***$406*** a day $0 $0	~~[$764]~~ ***$812*** (Part A Deductible) ~~[$191]~~ ***$203*** a day ~~[$382]~~ ***$406*** a day 100% of Medicare Eligible Expenses $0	$0 $0 $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:	All approved amounts All but ~~[$95.50]~~ ***$101.50*** a day	$0 Up to ~~[$95.50]~~ ***$101.50*** a day $0	$0 $0 All costs

First 20 days 21st thru 100th day 101st day and after	$0		
 BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
 HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	 All but very limited coinsurance for outpatient drugs and inpatient respite care	 $0	 Balance

PLAN F

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 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 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 $100 of Medicare-approved amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare-approved amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment: First $100 of Medicare-approved amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN F

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States: First $250 each calendar year Remainder of charges	$0 $0	$0 80% to a lifetime maximum benefit of $50,000	$250 20% and amounts over the $50,000 lifetime maximum

HIGH DEDUCTIBLE BENEFIT PLAN F

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 consecutive days.

** High Deductible Benefit Plan F offers benefits similar to the benefits offered by the Standardized Benefit Plan F except that the high deductible benefit plan requires the insured to pay a higher annual deductible. For the calendar ~~[years of 1998 and 1999,]~~ ***year 2002,*** the High Deductible Benefit Plan F requires the insured to pay an annual deductible in the amount of ~~[$1,500,]~~ ***$1,620,*** and thereafter the plan requires the insured to pay an annual deductible that is adjusted by the Commissioner in the manner set forth in subsection 2 of NAC 687B.311. Benefits for the High Deductible Benefit Plan F begin after the insured has paid the annual deductible for expenses that would ordinarily be paid by the plan, including, without limitation, the Medicare Part A deductible and the Medicare Part B deductible. The annual deductible must be paid in addition to the premium and in addition to any other deductibles relating to a specific benefit, including, without limitation, ~~[the deductible for prescription drugs and]~~ the deductible for emergency care received in a foreign country.

SERVICES	MEDICARE PAYS	AFTER YOU PAY ***THE $1,620*** DEDUCTIBLE	IN ADDITION TO ***THE $1,620*** DEDUCTIBLE

		PLAN PAYS**	YOU PAY**
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61st thru 90th day 91st day and after: While using 60 lifetime reserve days Once lifetime reserve days are used: Additional 365 days Beyond the additional 365 days	All but ~~[$764]~~ ***$812*** All but ~~[$191]~~ ***$203*** a day All but ~~[$382]~~ ***$406*** a day $0 $0	~~[$764]~~ ***$812*** (Part A Deductible) ~~[$191]~~ ***$203*** a day ~~[$382]~~ ***$406*** a day 100% of Medicare Eligible Expenses $0	$0 $0 $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 21st thru 100th day 101st day and after	All approved amounts All but ~~[$95.50]~~ ***$101.50*** a day $0	$0 Up to ~~[$95.50]~~ ***$101.50*** a day $0	$0 $0 All costs
BLOOD First 3 pints Additional amounts	$0 100%	3 pints $0	$0 $0

HIGH DEDUCTIBLE BENEFIT PLAN F

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD - ~~[CONTINUED]~~

(CONTINUED)

SERVICES	MEDICARE PAYS	AFTER YOU PAY ***THE $1,620*** DEDUCTIBLE PLAN PAYS**	IN ADDITION TO ***THE $1,620*** DEDUCTIBLE YOU PAY**
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

HIGH DEDUCTIBLE BENEFIT PLAN F

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 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. The $100 Part B Deductible will be applied toward the annual deductible for the calendar year set forth in NAC 687B.311.

** High Deductible Benefit Plan F offers benefits similar to the benefits offered by the Standardized Benefit Plan F except that the high deductible benefit plan requires the insured to pay a higher annual deductible. For the calendar ~~[years of 1998 and 1999,]~~ ***year 2002,*** the High Deductible Benefit Plan F requires the insured to pay an annual deductible in the amount of ~~[$1,500,]~~ ***$1,620,*** and thereafter the plan requires the insured to pay an annual deductible that is adjusted by the Commissioner in the manner set forth in subsection 2 of NAC 687B.311. Benefits for the High Deductible Benefit Plan F begin after the insured has paid the annual deductible for expenses that would ordinarily be paid by the plan, including, without limitation, the Medicare Part A deductible and the Medicare Part B deductible. The annual deductible must be paid in addition to the premium and in addition to any other deductibles relating to a specific benefit, including, without limitation, ~~[the deductible for prescription drugs and]~~ the deductible for emergency care received in a foreign country.

SERVICES	MEDICARE	AFTER YOU	IN ADDITION

	PAYS	PAY ***THE $1,620*** DEDUCTIBLE PLAN PAYS**	TO ***THE $1,620*** DEDUCTIBLE 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 $100 of Medicare-approved amounts* Remainder of Medicare-approved amounts Part B excess charges (above Medicare-approved amounts)	$0 80% $0	$100 (Part B Deductible) 20% 100%	$0 $0 $0
BLOOD First 3 pints Next $100 of Medicare-approved amounts* Remainder of Medicare-approved amounts	$0 $0 80%	All costs $100 (Part B Deductible) 20%	$0 $0 $0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE BENEFIT PLAN F

MEDICARE (PARTS A & B)

SERVICES	MEDICARE PAYS	AFTER YOU PAY ***THE $1,620*** DEDUCTIBLE PLAN PAYS**	IN ADDITION TO ***THE $1,620*** DEDUCTIBLE YOU PAY**
HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment: First $100 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% $0 80%	$0 $100 (Part B Deductible) 20%	$0 $0 $0

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States: First $250 each calendar year Remainder of charges	$0 $0	$0 80% to a lifetime maximum benefit of $50,000	$250 20% and amounts over the $50,000 lifetime maximum

PLAN G

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 consecutive days.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61st thru 90th day 91st day and after: While using 60 lifetime reserve days Once lifetime reserve days are used: Additional 365 days Beyond the additional 365 days	All but ~~[$764]~~ ***$812*** All but ~~[$191]~~ ***$203*** a day All but ~~[$382]~~ ***$406*** a day $0 $0	~~[$764]~~ ***$812*** (Part A Deductible) ~~[$191]~~ ***$203*** a day ~~[$382]~~ ***$406*** a day 100% of Medicare Eligible Expenses $0	$0 $0 $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:	All approved amounts All but ~~[$95.50]~~ ***$101.50*** a day	$0 Up to ~~[$95.50]~~ ***$101.50*** a day $0	$0 $0 All costs

First 20 days 21st thru 100th day 101st day and after	$0		
BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN G

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 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 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 $100 of Medicare-approved amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	80%	20%
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare-approved amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment: First $100 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% $0 80%	$0 $0 20%	$0 $100 (Part B Deductible) $0

PLAN G

MEDICARE (PARTS A & B) - [CONTINUED] *(CONTINUED)*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE (cont'd) AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan: Benefit for each visit Number of visits covered (must be received within 8 weeks of last Medicare-approved visit) Calendar year maximum	$0 $0 $0	Actual charges to $40 a visit Up to the number of Medicare-approved visits, not to exceed seven each week $1,600	Balance
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States: First $250 each calendar year Remainder of charges	$0 $0	$0 80% to a lifetime maximum benefit of $50,000	$250 20% and amounts over the $50,000 lifetime maximum

PLAN H

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 consecutive days.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61st thru 90th day 91st day and after: While using 60 lifetime reserve days Once lifetime reserve days are used: Additional 365 days Beyond the additional 365 days	All but ~~[$764]~~ ***$812*** All but ~~[$191]~~ ***$203*** a day All but ~~[$382]~~ ***$406*** a day $0 $0	~~[$764]~~ ***$812*** (Part A Deductible) ~~[$191]~~ ***$203*** a day ~~[$382]~~ ***$406*** a day 100% of Medicare Eligible Expenses $0	$0 $0 $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:	All approved amounts All but ~~[$95.50]~~ ***$101.50*** a day	$0 Up to ~~[$95.50]~~ ***$101.50*** a day $0	$0 $0 All costs

First 20 days 21st thru 100th day 101st day and after	$0		
BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN H

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 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 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 $100 of Medicare-approved amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare-approved amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE - APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment: First $100 of Medicare-approved amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN H

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States: First $250 each calendar year Remainder of charges	$0 $0	$0 80% of a lifetime maximum benefit of $50,000	$250 20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE First $250 each calendar year Next $2,500 each calendar year Over $2,500 each calendar year	$0 $0 $0	$0 50% - $1,250 calendar year maximum benefit $0	$250 50% All costs

PLAN I

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 consecutive days.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61st thru 90th day 91st day and after: While using 60 lifetime reserve days Once lifetime reserve days are used: Additional 365 days Beyond the additional 365 days	All but ~~[$764]~~ ***$812*** All but ~~[$191]~~ ***$203*** a day All but ~~[$382]~~ ***$406*** a day $0 $0	~~[$764]~~ ***$812*** (Part B Deductible) ~~[$191]~~ ***$203*** a day ~~[$382]~~ ***$406*** a day 100% of Medicare Eligible Expenses $0	$0 $0 $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:	All approved amounts All but ~~[$95.50]~~ ***$101.50*** a day	$0 Up to ~~[$95.50]~~ ***$101.50*** a day $0	$0 $0 All costs

First 20 days 21st thru 100th day 101st day and after	$0		
BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	 All but very limited coinsurance for outpatient drugs and inpatient respite care	 $0	 Balance

PLAN I

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 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 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 $100 of Medicare-approved amounts* Remainder of Medicare-approved amounts Part B excess charges (above Medicare-approved amounts)	$0 80% $0	$0 20% 100%	$100 (Part B Deductible) $0 $0
BLOOD First 3 pints Next $100 of Medicare-approved amounts* Remainder of Medicare-approved amounts	$0 $0 80%	All costs $0 20%	$0 $100 (Part B Deductible) $0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PART A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment: First $100 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% $0 80%	$0 $0 20%	$0 $100 (Part B Deductible) $0

PLAN I

MEDICARE (PARTS A & B) - ~~[CONTINUED]~~ ***(CONTINUED)***

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE (cont'd) AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan: Benefit for each visit Number of visits covered (must be received within 8 weeks of last Medicare-approved visit) Calendar year maximum	$0 $0 $0	Actual charges to $40 a visit Up to the number of Medicare-approved visits, not to exceed seven each week $1,600	Balance

OTHER BENEFITS

FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States: First $250 each calendar year Remainder of charges	$0 $0	$0 80% to a lifetime maximum benefit of $50,000	$250 20% and amounts over the $50,000 lifetime maximum

BASIC OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE First $250 each calendar year Next $2,500 each calendar year Over $2,500 each calendar year	$0 $0 $0	$0 50% - $1,250 calendar year maximum benefit $0	$250 50% All costs

PLAN J

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 consecutive days.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61st thru 90th day 91st day and after: While using 60 lifetime reserve days Once lifetime reserve days are used: Additional 365 days Beyond the additional 365 days	All but ~~[$764]~~ ***$812*** All but ~~[$191]~~ ***$203*** a day All but ~~[$382]~~ ***$406*** a day $0 $0	~~[$764]~~ ***$812*** (Part A Deductible) ~~[$191]~~ ***$203*** a day ~~[$382]~~ ***$406*** a day 100% of Medicare Eligible Expenses $0	$0 $0 $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:	All approved amounts All but ~~[$95.50]~~ ***$101.50*** a day	$0 Up to ~~[$95.50]~~ ***$101.50*** a day $0	$0 $0 All costs

First 20 days 21st thru 100th day 101st day and after	$0		
BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN J

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 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 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 $100 of Medicare-approved amounts* Remainder of Medicare-approved amounts Part B excess charges (above Medicare-approved amounts)	$0 80% $0	$100 (Part B Deductible) 20% 100%	$0 $0 $0
BLOOD First 3 pints Next $100 of Medicare-approved amounts* Remainder of Medicare-approved amounts	$0 $0 80%	All costs $100 (Part B Deductible) 20%	$0 $0 $0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment: First $100 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% $0 80%	$0 $100 (Part B Deductible) 20%	$0 $0 $0

PLAN J

MEDICARE (PARTS A & B) - ~~[CONTINUED]~~ ***(CONTINUED)***

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE (cont'd) AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan: Benefit for each visit Number of visits covered (must be received within 8 weeks of last Medicare-approved visit) Calendar year maximum	$0 $0 $0	Actual charges to $40 a visit Up to the number of Medicare-approved visits, not to exceed seven each week $1,600	Balance

OTHER BENEFITS

FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States: First $250 each calendar year Remainder of charges	$0 $0	$0 80% to a lifetime maximum benefit of $50,000	$250 20% and amounts over the $50,000 lifetime maximum

EXTENDED OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE First $250 each calendar year Next $6,000 each calendar year Over $6,000 each calendar year	$0 $0 $0	$0 50% - $3,000 calendar year maximum benefit $0	$250 50% All costs

PLAN J

OTHER BENEFITS [(cont'd)] ***(CONTINUED)***

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE** Some annual physical and preventive tests and services such as digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare: First $120 each calendar year Additional charges	 $0 $0	 $120 $0	 $0 All costs

** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the "Guide to Health Insurance for People with Medicare" which must be provided by an issuer to an applicant pursuant to NAC 687B.240. For help in understanding your health insurance, you may contact the Commissioner of Insurance or the Nevada [Medicare Information, Counseling and Assistance] ***State Health Insurance Advisory*** Program ***(SHIP)*** of the Aging Services Division of the Department of Human Resources.

HIGH DEDUCTIBLE BENEFIT PLAN J

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 consecutive days.

** High Deductible Benefit Plan J offers benefits similar to the benefits offered by the Standardized Benefit Plan J except that the high deductible benefit plan requires the insured to pay a higher annual deductible. For the calendar ~~[years of 1998 and 1999,]~~ ***year 2002,*** the High Deductible Benefit Plan J requires the insured to pay an annual deductible in the amount of ~~[$1,500,]~~ ***$1,620,*** and thereafter the plan requires the insured to pay an annual deductible that is adjusted by the Commissioner in the manner set forth in subsection 2 of NAC ~~[687B.311.]~~ ***687B.319.*** Benefits for the High Deductible Benefit Plan J begin after the insured has paid the annual deductible for expenses that would ordinarily be paid by the plan, including, without limitation, the Medicare Part A deductible and the Medicare Part B deductible. The annual deductible must be paid in addition to the premium and in addition to any other deductibles relating to a specific benefit, including, without limitation, the deductible for prescription drugs and the deductible for emergency care received in a foreign country.

SERVICES	MEDICARE PAYS	AFTER YOU PAY ***THE $1,620*** DEDUCTIBLE	IN ADDITION TO ***THE $1,620*** DEDUCTIBLE

		PLAN PAYS**	YOU PAY**
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61st thru 90th day 91st day and after: While using 60 lifetime reserve days Once lifetime reserve days are used: Additional 365 days Beyond the additional 365 days	All but ~~[$764]~~ ***$812*** All but ~~[$191]~~ ***$203*** a day All but ~~[$382]~~ ***$406*** a day $0 $0	~~[$764]~~ ***$812*** (Part A Deductible) ~~[$191]~~ ***$203*** a day ~~[$382]~~ ***$406*** a day 100% of Medicare Eligible Expenses $0	$0 $0 $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 21st thru 100th day 101st day and after	All approved amounts All but ~~[$95.50]~~ ***$101.50*** a day $0	$0 Up to ~~[$95.50]~~ ***$101.50*** a day $0	$0 $0 All costs
BLOOD First 3 pints Additional amounts	$0 100%	3 pints $0	$0 $0

HIGH DEDUCTIBLE BENEFIT PLAN J

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD - ~~[CONTINUED]~~

(CONTINUED)

SERVICES	MEDICARE PAYS	AFTER YOU PAY ***THE $1,620*** DEDUCTIBLE PLAN PAYS**	IN ADDITION TO ***THE $1,620*** DEDUCTIBLE YOU PAY**
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

HIGH DEDUCTIBLE BENEFIT PLAN J

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 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. The $100 Part B Deductible will be applied toward the annual deductible for the calendar year set forth in NAC 687B.319.

** High Deductible Benefit Plan J offers benefits similar to the benefits offered by the Standardized Benefit Plan J except that the high deductible benefit plan requires the insured to pay a higher deductible. For the calendar ~~[years of 1998 and 1999,]~~ ***year 2002,*** the High Deductible Benefit Plan J requires the insured to pay an annual deductible in the amount of ~~[$1,500,]~~ ***$1,620,*** and thereafter the plan requires the insured to pay an annual deductible that is adjusted by the Commissioner in the manner set forth in subsection 2 of NAC ~~[687B.311.]~~ ***687B.319.*** Benefits for the High Deductible Benefit Plan J begin after the insured has paid the annual deductible for expenses that would ordinarily be paid by the plan, including, without limitation, the Medicare Part A deductible and the Medicare Part B deductible. The annual deductible must be paid in addition to the premium and in addition to any other deductibles relating to a specific benefit, including, without limitation, the deductible for prescription drugs and the deductible for emergency care received in a foreign country.

SERVICES	MEDICARE	AFTER YOU PAY	IN ADDITION TO

	PAYS	***THE $1,620*** DEDUCTIBLE PLAN PAYS**	***THE $1,620*** DEDUCTIBLE 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 $100 of Medicare-approved amounts* Remainder of Medicare-approved amounts Part B excess charges (above Medicare-approved amounts)	$0 80% $0	$100 (Part B Deductible) 20% 100%	$0 $0 $0
BLOOD First 3 pints Next $100 of Medicare-approved amounts* Remainder of Medicare-approved amounts	$0 $0 80%	All costs $100 (Part B Deductible) 20%	$0 $0 $0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE BENEFIT PLAN J

MEDICARE (PARTS A & B)

SERVICES	MEDICARE PAYS	AFTER YOU PAY ***THE $1,620*** DEDUCTIBLE PLAN PAYS**	IN ADDITION TO ***THE $1,620*** DEDUCTIBLE YOU PAY**
HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment: First $100 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% $0 80%	$0 $100 (Part B Deductible) 20%	$0 $0 $0
HOME HEALTH CARE AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan: Benefit for each visit Number of visits covered (must be received within 8 weeks of last Medicare-approved visit) Calendar year maximum	$0 $0 $0	Actual charges to $40 a visit Up to the number of Medicare-approved visits, not to exceed seven each week $1,600	Balance

OTHER BENEFITS

FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States: First $250 each calendar year Remainder of charges	$0 $0	$0 80% to a lifetime maximum benefit of $50,000	$250 20% and amounts over the $50,000 lifetime maximum
EXTENDED OUTPATIENT PRESCRIPTION DRUGS -NOT COVERED BY MEDICARE First $250 each calendar year Next $6,000 each calendar year Over $6,000 each calendar year	$0 $0 $0	$0 50% - $3,000 calendar year maximum benefit $0	$250 50% All costs

HIGH DEDUCTIBLE BENEFIT PLAN J

OTHER BENEFITS [(cont'd)] ***(CONTINUED)***

SERVICES	MEDICARE PAYS	AFTER YOU PAY ***THE $1,620*** DEDUCTIBLE PLAN PAYS	IN ADDITION TO ***THE $1,620*** DEDUCTIBLE YOU PAY
PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE*** Some annual physical and preventive tests and services such as digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare:			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

*** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the "Guide to Health Insurance for People with Medicare" which must be provided by an issuer to an applicant pursuant to NAC 687B.240. For help in understanding your health insurance, you may contact the Commissioner of Insurance or the Nevada [Medicare Information, Counseling and Assistance] ***State Health Insurance Advisory*** Program ***(SHIP)*** of the Aging Services Division of the Department of Human Resources.

Sec. 13. NAC 687B.311 is hereby amended to read as follows:

687B.311 1. A benefit plan to supplement Medicare which is designated as Standardized Benefit Plan F or High Deductible Benefit Plan F must provide the following benefits:

(a) The benefits required by NAC 687B.290.

(b) Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

(c) For Medicare Part A eligible expenses for posthospital care received at a skilled nursing facility, coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in any Medicare benefit period.

(d) Coverage for all of the Medicare Part B deductible amount per calendar year, regardless of whether the insured has been confined in a hospital.

(e) Coverage for 100 percent of the Medicare Part B excess charge calculated by determining the difference between the actual Medicare Part B charge as billed, not to exceed any limitation on that charge established by the Medicare program or state law, and the Medicare Part B charge that has been approved.

(f) Coverage of Medicare eligible expenses for 80 percent of the billed charges for medically necessary emergency care received in a foreign country to the extent not covered by Medicare, if such care would have been covered by Medicare if provided in the United States and the care began during the first 60 consecutive days of the trip outside the United States. The benefit is subject to the payment of a deductible of $250 per calendar year and a lifetime maximum benefit of $50,000. As used in this subsection, “emergency care” means medical care needed immediately because of a sudden and unexpected injury or illness.

2. In addition to the requirements of subsection 1, a benefit plan to supplement Medicare which is designated as High Deductible Benefit Plan F must require the insured to pay an annual deductible in the amount of [~~$1,500~~] ***$1,620*** for the calendar [~~years of 1998 and 1999~~] ***year 2002*** and in an amount that is adjusted by the commissioner each year thereafter in the manner required pursuant to section 1882(p)(11)(C)(ii) of the Social Security Act, 42 U.S.C. § 1395ss(p)(11)(C)(ii). The deductible must be paid in addition to the premium and in addition to any other deductibles relating to a specific benefit.

Sec. 14. NAC 687B.319 is hereby amended to read as follows:

687B.319 1. A benefit plan to supplement Medicare which is designated as Standardized Benefit Plan J or High Deductible Benefit Plan J must provide the following benefits:

(a) The benefits required by NAC 687B.290.

(b) Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

(c) For Medicare Part A eligible expenses for posthospital care received at a skilled nursing facility, coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in any Medicare benefit period.

(d) Coverage for all of the Medicare Part B deductible amount per calendar year, regardless of whether the insured has been confined in a hospital.

(e) Coverage for 100 percent of the Medicare Part B excess charge calculated by determining the difference between the actual Medicare Part B charge as billed, not to exceed any limitation on that charge established by the Medicare program or state law, and the Medicare Part B charge that has been approved.

(f) As an extended benefit, coverage for 50 percent of the charges for prescription drugs received as an outpatient, after payment of a deductible of $250 per calendar year, not to exceed $3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare.

(g) Coverage of Medicare eligible expenses for 80 percent of the billed charges for medically necessary emergency care received in a foreign country to the extent not covered by Medicare, if such care would have been covered by Medicare if provided in the United States and the care began during the first 60 consecutive days of the trip outside the United States. The benefit is subject to the payment of a deductible of $250 per calendar year and a lifetime maximum benefit of $50,000. As used in this subsection, "emergency care" means medical care needed immediately because of a sudden and unexpected injury or illness.

(h) Coverage for the following preventative health services for the actual amount charged for each service not to exceed 100 percent of the amount approved by Medicare for that service, as identified in the American Medical Association's Current Procedural Terminology (AMA CPT) codes, not to exceed $120 per year, to the extent not covered by Medicare:

(1) An annual clinical medical history and physical examination that may include the tests and services set forth in subparagraph (2) and educational services that address measures to be taken for preventative health care.

(2) Any one or a combination of the following tests and services if the frequency is considered medically appropriate:

(I) A digital rectal examination.

(II) A dipstick urinalysis for hematuria, bacteriuria and proteinuria.

(III) A pure tone hearing test using air only administered or ordered by a physician.

(IV) A serum cholesterol screening every 5 years.

(V) A thyroid function test.

(VI) A screening for diabetes.

(3) A vaccination for tetanus and diphtheria administered every 10 years.

(4) Any other tests or preventative measures deemed appropriate by the attending physician.

(i) Coverage for short-term services that provide to a person recovering from an illness, injury or surgery in his home, assistance with daily activities such as bathing, dressing, personal hygiene, eating, ambulating, administering prescription drugs and changing bandages and other dressings. The coverage must comply with the requirements of NAC 687B.325.

2. In addition to the requirements of subsection 1, a benefit plan to supplement Medicare which is designated as High Deductible Benefit Plan J must require the insured to pay an annual deductible in the amount of ~~[$1,500]~~ ***$1,620*** for the calendar ~~[years of 1998 and 1999]~~ ***year of 2002*** and in an amount that is adjusted by the commissioner each year thereafter in the manner required pursuant to section 1882(p)(11)(C)(ii) of the Social Security Act, 42 U.S.C. § 1395(p)(11)(C)(ii). The deductible must be paid in addition to the premium and in addition to any other deductibles relating to a specific benefit.

NOTICE OF ADOPTION OF PROPOSED REGULATION
LCB File No. R075-02

The Commissioner of Insurance adopted regulations assigned LCB File No. R075-02 which pertain to chapter 687B of the Nevada Administrative Code on August 16, 2002.

Notice date: 5/29/2002
Hearing date: 6/28/2002
Date of adoption by agency: 8/16/2002
Filing date: 9/20/2002

INFORMATIONAL STATEMENT

A hearing was held on June 28, 2002, at the offices of the Department of Business and Industry, Division of Insurance (Division), 788 Fairview Drive, Suite 300, Carson City, Nevada, 89701, with a simultaneous video-conference conducted at the Bradley Building, 2501 E. Sahara Avenue, Manufactured Housing Division Conference Room, 2nd Floor, Las Vegas, Nevada 89104, regarding the adoption of the regulation concerning Medicare Supplement Plans.

Public comment was solicited by posting notice of the hearing in the following public locations: 788 Fairview Drive, Legislative Counsel Bureau, Capitol Building Lobby, Blasdel Building, Carson City Courthouse, State Library, Clark County Library, Capitol Press Room and the Division's Las Vegas Office.

In addition, the Division maintains a list of interested parties, comprised mainly of insurance companies, agencies and other persons regulated by the Division. These persons were notified of the hearing and that copies of the regulation could be obtained from or examined at the offices of the Division in Carson City.

Oral testimony was received by the Division. Copies of any comments received by the Division can be obtained from the Division at 788 Fairview Drive, Suite 300, Carson City, Nevada 89701, (775) 687-4270.

Considering the comments by those attending the hearing, the Commissioner has issued an order adopting the regulation as a permanent regulation of the Division.

Based upon the comments received at the hearing, the regulation was changed from the proposed regulation as follows:

1. Reference to paragraph (d) was added to subsection 2 of section 4, which now reads as follows: "In lieu of using the date of termination of enrollment for purposes of this section, a person described in paragraph (c) ***and (d)*** of subsection 1 . . . ."

The economic impact of the regulation is as follows:

(a) Regulated Industry: Minimal.

(b) Public: Minimal.

The regulation imposes no direct costs upon members of the public at large. The regulation imposes no direct cost upon the agency to enforce the regulation.

This regulation does not duplicate or overlap any other regulation.

STATE OF NEVADA
DEPARTMENT OF BUSINESS AND INDUSTRY
DIVISION OF INSURANCE

IN THE MATTER OF	**CAUSE NO. 02.124** **LCB File No. R075-02**
A REGULATION CONCERNING MEDICARE SUPPLEMENT PLANS. ______________________/	**SUMMARY OF PROCEEDINGS AND ORDER**

SUMMARY OF PROCEEDINGS

A public workshop, as required by NRS 233B.061, on the proposed regulation relating to Medicare Supplement plans, LCB File No. R075-02, was held before Alice A. Molasky-Arman, Commissioner of Insurance, on June 28, 2002, in Carson City, Nevada. A public hearing on the proposed regulation was also held before Commissioner Molasky-Arman on June 28, 2002, in Carson City, Nevada. The regulation is proposed under the authority of NRS § 1, NRS 679B.130 and 687B.430.

The Department of Business and Industry, Division of Insurance (Division) did not receive any written comments. Eight Division individuals attended the hearing. There were no public attendees present. Guy Perkins, representing the Division, provided testimony before the Hearing Officer.

Mr. Perkins testified that the intent of the regulation was to amend those sections of Chapter 687B of the Nevada Administrative Code that have been amended by the NAIC Medicare Supplement Model Regulation. Technical changes have been made to the eligibility standards for Medicare Supplement plans for people who have become disenrolled under a Medicare + Choice plan or a PACE program (Program for All-Inclusive Care for the Elderly); and an allowance for co-payments has been added to correspond with the provision for a "prospective payment system" under the 12 standard Medicare Supplement plans.

Mr. Perkins identified a section that the Legislative Counsel Bureau (LCB) amended by removing the reference to PACE from paragraph (c) of subsection 1 of section 3 of the proposed regulation. The LCB needs to add a reference to paragraph (d) of the new subsection 2 of section 4 in order to include PACE. Commissioner Molasky-Arman asked Division staff to contact LCB and make the correction to include PACE.

ORDER OF THE COMMISSIONER

Having reviewed the record in this matter, it is hereby ordered that the proposed regulation concerning Medicare Supplement plans, LCB File No. R075-02, be adopted, as amended, as a permanent regulation of the Division.

SO ORDERED this ______ day of ________________________, 2002.

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ALICE A. MOLASKY-ARMAN
Commissioner of Insurance