ADOPTED REGULATION OF THE

COMMISSIONER OF INSURANCE

LCB File No. R027-04

Effective August 2, 2004

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

AUTHORITY: §§1-9, NRS 679B.130 and 687B.430.

A REGULATION relating to insurance; requiring an issuer of a policy to supplement Medicare or certificate to provide standardized benefit plans to certain insureds; requiring an issuer to provide notice of lapse of a policy to supplement Medicare or certificate for nonpayment of a premium; revising the outline of coverage for policies supplementary to Medicare; and providing other matters properly relating thereto.

Section 1. Chapter 687B of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 5, inclusive, of this regulation.

Sec. 2. ***1. Except as otherwise provided in subsection 2, an issuer shall, at the request of an insured, replace a policy to supplement Medicare which was issued before January 1, 1992, or a certificate which was issued before January 1, 1992, with any standardized benefit plan offered by the issuer. An insured may submit a request to replace a policy to supplement Medicare or certificate pursuant to this subsection not more than once.***

2. An issuer may refuse a request made pursuant to subsection 1 for the issuance of a standardized benefit plan to replace a policy to supplement Medicare or certificate which was issued before January 1, 1992, if:

(a) The standardized benefit plan includes more coverage for prescription drugs than the policy to supplement Medicare or certificate; or

(b) The insured does not otherwise qualify for the standardized benefit plan.

3. If an insured requests a standardized benefit plan to replace a policy to supplement Medicare or certificate pursuant to subsection 1 from an issuer that establishes the rates of a standardized benefit plan on the basis of the age of an applicant, the issuer must use the attained age of the insured on the date his request is submitted to establish the rate for the standardized benefit plan.

Sec. 3. *1. An issuer may not terminate a policy to supplement Medicare or certificate advertised, solicited or issued for delivery in this state based on the lack of payment of the premium on or before the date the premium is required to be paid, unless the insured and each person designated by the insured pursuant to section 4 of this regulation has received a notice sent by the issuer stating that the policy has lapsed and may be terminated for nonpayment of the premium.*

2. For the purposes of this section, the notice:

(a) Must be sent by first-class mail, postage prepaid, and addressed to the person at his last known address.

(b) Shall be deemed to have been received by the insured or the person designated by the insured pursuant to section 4 of this regulation on the fifth day after the date on which the issuer mails the notice.

Sec. 4. *1. An issuer shall not issue a policy to supplement Medicare or certificate advertised, solicited or issued for delivery in this state until the issuer has received from the applicant a designation of one or more persons to receive notice of lapse or a waiver pursuant to subsection 2.*

2. Each applicant shall submit to the issuer of the policy to supplement Medicare or the certificate:

(a) A written designation of one or more persons other than the applicant to receive notice from the issuer that the policy to supplement Medicare or the certificate has lapsed and may be terminated for nonpayment of a premium; or

(b) A written waiver which is dated and signed by the applicant and which:

(1) Indicates that the applicant does not wish to designate any person other than the applicant to receive notice that the policy to supplement Medicare or the certificate has lapsed and may be terminated for nonpayment of a premium; and

(2) Includes the statement required pursuant to subsection 4.

3. The form provided by an issuer for making a designation pursuant to paragraph (a) of subsection 2 must provide space clearly designated for listing at least one person to receive notice. A designation made pursuant to paragraph (a) of subsection 2:

(a) Must include the full name and address of the person designated; and

(b) Does not constitute acceptance by the person designated of any liability for services provided to the applicant.

4. A waiver submitted pursuant to paragraph (b) of subsection 2, must contain the following statement:

Protection Against Unintended Lapse

I understand that I have the right to designate at least one person other than myself to receive notice of lapse of this policy to supplement Medicare or certificate for nonpayment of a premium. I elect NOT to designate a person to receive this notice.

5. An issuer shall, at least once every 2 years, notify an insured of his right to make or change a written designation pursuant to subsection 2.

Sec. 5. ***A policy to supplement Medicare or certificate advertised, solicited or issued for delivery in this state must include a provision which provides that, in the event of a lapse in coverage of the policy or certificate for nonpayment of a premium, coverage will be reinstated if:***

1. Reinstatement is requested within 2 months after the date of lapse of coverage; and

2. Proof of cognitive impairment or loss of functional capacity of the insured before the lapse of coverage or the expiration of any grace period contained in the policy to supplement Medicare or the certificate is provided to the issuer.

Sec. 6. NAC 687B.200 is hereby amended to read as follows:

687B.200 As used in NAC 687B.200 to 687B.330, inclusive, ***and sections 2 to 5, inclusive, of this regulation,*** unless the context otherwise requires, the words and terms defined in NAC 687B.201 to 687B.2045, inclusive, have the meanings ascribed to them in those sections.

Sec. 7. 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 ***the*** 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.]~~ ***7.***

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. ***An insured may contact the Commissioner of Insurance or the Nevada State Health Insurance Advisory Program (SHIP) of the Aging Services Division of the Department of Human Resources for help in understanding his health insurance.***

7. 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) 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 year 2002, the High Deductible Benefit Plans F and J require the insured to pay an annual deductible in the amount of $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.]~~ ***The annual deductibles for the High Deductible Benefit Plans F and J are subject to change. For the current deductibles, 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. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. The annual deductibles for the High Deductible Benefit Plans F and J may be adjusted annually by the Secretary of the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for All Urban Consumers published by the United States Department of Labor for the calendar year ending on July 31 of the immediately preceding year, and rounded to the nearest multiple of $10.*** 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 *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.

***** 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.***

****** The plan pays all costs that Medicare does not pay.***

******* You pay all costs that Medicare does not pay.***

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	~~[All but $812]~~ **	$0	~~[$812]~~ **** (Part A Deductible)
61st thru 90th day	~~[All but $203 a day]~~ **	~~[$203 a day]~~ ***	$0
91st day and after:			
While using 60 lifetime reserve days	~~[All but $406 a day]~~ **	~~[$406 a day]~~ ***	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	~~[All but $101.50 a day]~~ **	$0	~~[Up to $101.50 a day]~~ ****
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE 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*	$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

**** 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
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 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.

***** 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.***

****** The plan pays all costs that Medicare does not pay.***

******* You pay all costs that Medicare does not pay.***

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	~~[All but $812]~~ **	~~[$812]~~ *** (Part A Deductible)	$0
61st thru 90th day	~~[All but $203 a day]~~ **	~~[$203 a day]~~ ***	$0
91st day and after:			
While using 60 lifetime reserve days	~~[All but $406 a day]~~ **	~~[$406 a day]~~ ***	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts ~~[All but $101.50 a day]~~	$0	$0 ~~[Up to $101.50 a day]~~ ****
21st thru 100th day	**	$0	
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$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*	$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

**** 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
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 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.

******* ***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.***

********* ***The plan pays all costs that Medicare does not pay.***

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	~~[All but $812]~~ **	~~[$812]~~ *** (Part A Deductible)	$0
61st thru 90th day	~~[All but $203 a day]~~ **	~~[$203 a day]~~ ***	$0
91st day and after:			
While using 60 lifetime reserve days	~~[All but $406 a day]~~ **	~~[$406 a day]~~ ***	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts ~~[All but $101.50 a day]~~	$0	$0
21st thru 100th day	**	~~[Up to $101.50 a day]~~ ***	$0
101st day and after	$0	$0	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 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

**** 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
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

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	$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 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.

***** 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.***

****** The plan pays all costs that Medicare does not pay.***

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	~~[All but $812]~~ **	~~[$812]~~ *** (Part A Deductible)	$0
61st thru 90th day	~~[All but $203 a day]~~ **	~~[$203 a day]~~ ***	$0
91st day and after:			
While using 60 lifetime reserve days	~~[All but $406 a day]~~ **	~~[$406 a day]~~ ***	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts ~~[All but $101.50 a day]~~	$0	$0
21st thru 100th day	**	~~[Up to $101.50 a day]~~ ***	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$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 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

**** 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
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

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

PLAN D

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 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.

***** 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.***

****** The plan pays all costs that Medicare does not pay.***

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

SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts ~~[All but $101.50 a day]~~	$0	$0
21st thru 100th day	**	~~[Up to $101.50 a day]~~ ***	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$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*	$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

**** 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
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 E

OTHER BENEFITS - NOT COVERED BY MEDICARE

**** 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.***

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	$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

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 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.

***** 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.***

****** The plan pays all costs that Medicare does not pay.***

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	~~[All but $812]~~ **	~~[$812]~~ *** (Part A Deductible)	$0
61st thru 90th day	~~[All but $203 a day]~~ **	~~[$203 a day]~~ ***	$0
91st day and after:			
While using 60 lifetime reserve days	~~[All but $406 a day]~~ **	~~[$406 a day]~~ ***	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts ~~[All but $101.50 a day]~~	$0	$0
21st thru 100th day	**	~~[Up to $101.50 a day]~~ ***	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$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

**** 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
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

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	$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

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.

** ***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.***

*** ***The plan pays the costs that Medicare does not pay after you pay the deductible.***

**** ***The*** 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 year 2002, the High Deductible Benefit Plan F requires the insured to pay an annual deductible in the amount of $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.]~~ ***The annual deductible for the High Deductible Benefit Plan F is subject to change. For the current deductible, 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. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. The annual deductible for the High Deductible Benefit Plan F may be adjusted annually by the Secretary of the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for All Urban Consumers published by the United States Department of Labor for the calendar year ending on July 31 of the immediately preceding year, and rounded to the nearest multiple of $10. 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 emergency care received in a foreign country.

SERVICES	MEDICARE PAYS	AFTER YOU PAY THE ~~[$1,620]~~ DEDUCTIBLE PLAN PAYS ~~[**]~~ ****	IN ADDITION TO THE ~~[$1,620]~~ DEDUCTIBLE YOU PAY ~~[**]~~ ****
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	~~[All but $812]~~ **	~~[$812]~~ *** (Part A Deductible)	$0
61st thru 90th day	~~[All but $203 a day]~~ **	~~[$203 a day]~~ ***	$0
91st day and after:			
While using 60 lifetime reserve days	~~[All but $406 a day]~~ **	~~[$406 a day]~~ ***	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
Beyond the additional 365 days	$0	$0	All costs

SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	 All approved amounts<br~~[All but $101.50 a day]~~ ** $0	 $0<br~~[Up to $101.50 a day]~~ *** $0	 $0 $0 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

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.

** ***The*** 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 year 2002, the High Deductible Benefit Plan F requires the insured to pay an annual deductible in the amount of $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.]~~ ***The annual deductible for the High Deductible Benefit Plan F is subject to change. For the current deductible, 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. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. The annual deductible for the High Deductible Benefit Plan F may be adjusted annually by the Secretary of the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for All Urban Consumers published by the United States Department of Labor for the calendar year ending on July 31 of the immediately preceding year, and rounded to the nearest multiple of $10.*** 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 emergency care received in a foreign country.

SERVICES	MEDICARE PAYS	AFTER YOU PAY THE ~~[$1,620]~~ DEDUCTIBLE PLAN PAYS**	IN ADDITION 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*	$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

HIGH DEDUCTIBLE BENEFIT PLAN F

MEDICARE (PARTS A & B)

**** 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.***

***** The 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. The annual deductible for the High Deductible Benefit Plan F is subject to change. For the current deductible, 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. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. The annual deductible for the High Deductible Benefit Plan F may be adjusted annually by the Secretary of the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for All Urban Consumers published by the United States Department of Labor for the calendar year ending on July 31 of the immediately preceding year, and rounded to the nearest multiple of $10. 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 emergency care received in a foreign country.***

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	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

OTHER BENEFITS - NOT COVERED BY MEDICARE

**** The 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. The annual deductible for the High Deductible Benefit Plan F is subject to change. For the current deductible, 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. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. The annual deductible for the High Deductible Benefit Plan F may be adjusted annually by the Secretary of the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for All Urban Consumers published by the United States Department of Labor for the calendar year ending on July 31 of the immediately preceding year, and rounded to the nearest multiple of $10. 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 emergency care received in a foreign country.***

SERVICES	MEDICARE PAYS	AFTER YOU PAY THE ~~[$1,620]~~ DEDUCTIBLE PLAN PAYS ~~[**]~~ *	IN ADDITION TO THE ~~[$1,620]~~ DEDUCTIBLE 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	$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 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.

***** 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.***

****** The plan pays the costs that Medicare does not pay.***

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	~~[All but $812]~~ **	~~[$812]~~ *** (Part A Deductible)	$0
61st thru 90th day	~~[All but $203 a day]~~ **	~~[$203 a day]~~ ***	$0
91st day and after:			
While using 60 lifetime reserve days	~~[All but $406 a day]~~ **	~~[$406 a day]~~ ***	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts ~~[All but $101.50 a day]~~	$0	$0
21st thru 100th day	**	~~[Up to $101.50 a day]~~ ***	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$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

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

PLAN G

PARTS A & B

**** 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
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
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	

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 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.

***** Medicare benefits are subject to change. For the current Medicare benefits, 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.***

****** The plan pays the costs that Medicare does not pay.***

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	~~[All but $812]~~ **	~~[$812]~~ *** (Part A Deductible)	$0
61st thru 90th day	~~[All but $203 a day]~~ **	~~[$203 a day]~~ ***	$0
91st day and after:			
While using 60 lifetime reserve days	~~[All but $406 a day]~~ **	~~[$406 a day]~~ ***	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts ~~[All but $101.50 a day]~~	$0	$0
21st thru 100th day	**	~~[Up to $101.50 a day]~~ ***	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$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

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

PLAN H

PARTS A & B

**** 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
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

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	$0	$0	$250
Remainder of charges	$0	80% of a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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

***** Medicare benefits are subject to change. For the current Medicare benefits, 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.***

****** The plan pays the costs that Medicare does not pay.***

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	~~[All but $812]~~ **	~~[$812]~~ *** (Part B Deductible)	$0
61st thru 90th day	~~[All but $203 a day]~~ **	~~[$203 a day]~~ ***	$0
91st day and after:			
While using 60 lifetime reserve days	~~[All but $406 a day]~~ **	~~[$406 a day]~~ ***	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts ~~[All but $101.50 a day]~~	$0	$0
21st thru 100th day	**	~~[Up to $101.50 a day]~~ ***	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$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

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	100%	$0
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

PLAN I

PARTS A & B

**** 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
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
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

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

***** Medicare benefits are subject to change. For the current Medicare benefits, 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.***

***** *The plan pays the costs that Medicare does not pay.***

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	~~[All but $812]~~ **	~~[$812]~~ *** (Part A Deductible)	$0
61st thru 90th day	~~[All but $203 a day]~~ **	~~[$203 a day]~~ ***	$0
91st day and after:			
While using 60 lifetime reserve days	~~[All but $406 a day]~~ **	~~[$406 a day]~~ ***	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts ~~[All but $101.50 a day]~~	$0	$0
21st thru 100th day	**	~~[Up to $101.50 a day]~~ ***	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$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*	$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

**** 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
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

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	

PLAN J

OTHER BENEFITS

**** Medicare benefits are subject to change. For the current Medicare benefits, 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.***

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
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
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 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.

** ***Medicare benefits are subject to change. For the current Medicare benefits, 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.***

*** ***The plan pays the costs that Medicare does not pay after you pay the deductible.***

**** ***The*** 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 year 2002, the High Deductible Benefit Plan J requires the insured to pay an annual deductible in the amount of $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.319.]~~ ***The annual deductible for the High Deductible Benefit Plan J is subject to change. For the current deductible, 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. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. The annual deductible for the High Deductible Benefit Plan J may be adjusted annually by the Secretary of the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for All Urban Consumers published by the United States Department of Labor for the calendar year ending on July 31 of the immediately preceding year, and rounded to the nearest multiple of $10.*** 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 PLAN PAYS [**] ****	IN ADDITION TO THE [$1,620] DEDUCTIBLE YOU PAY [**] ****
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	[All but $812] **	[$812] *** (Part A Deductible)	$0
61st thru 90th day	[All but $203 a day] **	[$203 a day] ***	$0
91st day and after:			
While using 60 lifetime reserve days	[All but $406 a day] **	[$406 a day] ***	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts [All but $101.50 a day]	$0	$0
21st thru 100th day	**	[Up to $101.50 a day] ***	$0
101st day and after	$0	$0	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

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.

** ***The*** 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 year 2002, the High Deductible Benefit Plan J requires the insured to pay an annual deductible in the amount of $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.319.]~~ ***The annual deductible for the High Deductible Benefit Plan J is subject to change. For the current deductible, 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. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. The annual deductible for the High Deductible Benefit Plan J may be adjusted annually by the Secretary of the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for All Urban Consumers published by the United States Department of Labor for the calendar year ending on July 31 of the immediately preceding year, and rounded to the nearest multiple of $10.*** 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 PLAN PAYS**	IN ADDITION 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*	$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

**** 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.***

***** The 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. The annual deductible for the High Deductible Benefit Plan J is subject to change. For the current deductible, 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. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. The annual deductible for the High Deductible Benefit Plan J may be adjusted annually by the Secretary of the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for All Urban Consumers published by the United States Department of Labor for the calendar year ending on July 31 of the immediately preceding year, and rounded to the nearest multiple of $10. 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 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	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
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	$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	

HIGH DEDUCTIBLE BENEFIT PLAN J

OTHER BENEFITS

**** The 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. The annual deductible for***

the High Deductible Benefit Plan J is subject to change. For the current deductible, 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. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. The annual deductible for the High Deductible Benefit Plan J may be adjusted annually by the Secretary of the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for All Urban Consumers published by the United States Department of Labor for the calendar year ending on July 31 of the immediately preceding year, and rounded to the nearest multiple of $10. 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.

*** 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.***

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

EXTENDED OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE **			
First $250 each calendar year	$0	$0	$250
Next $6,000 each calendar year	$0	50% - $3,000 calendar year maximum benefit	50%
Over $6,000 each calendar year	$0	$0	All costs
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 State Health Insurance Advisory Program (SHIP) of the Aging Services Division of the Department of Human Resources.]~~

Sec. 8. 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,]~~ ***paragraph,*** "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 $1,620 for the calendar 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 annual deductible for High Deductible Benefit Plan F is subject to change. For the current deductible, 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. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to NAC 687B.250 must specify the current amount of the deductible. The annual deductible for High Deductible Benefit Plan F may be adjusted annually by the Secretary of the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for All Urban Consumers published by the United States Department of Labor for the calendar year ending on July 31 of the immediately preceding year, and rounded to the nearest multiple of $10.* The deductible must be paid in addition to the premium and in addition to any other deductibles relating to a specific benefit.

Sec. 9. 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,]~~ ***paragraph,*** "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 $1,620 for the calendar 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 annual deductible for High Deductible Benefit Plan J is subject to change. For the current deductible, 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. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to NAC 687B.250 must specify the current amount of the deductible. The annual deductible for High Deductible Benefit Plans F and J may be adjusted annually by the***

Secretary of the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for All Urban Consumers published by the United States Department of Labor for the calendar year ending on July 31 of the immediately preceding year, and rounded to the nearest multiple of $10. 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. R027-04

The Commissioner of Insurance adopted regulations assigned LCB File No. R027-04 which pertain to chapter 687B of the Nevada Administrative Code on June 21, 2004.

Notice date: 2/19/2004 **Date of adoption by agency:** 6/21/2004
Hearing date: 3/23/2004 **Filing date:** 8/2/2004

INFORMATIONAL STATEMENT

A hearing was held on March 23, 2004, 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 insurance policies.

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.

The hearing was attended by 19 individuals. The following persons provided testimony before the Hearing Officer: Kimberly Everett, representing the Division; Carl Miller, representing Anthem Blue Cross and Blue Shield; Janice Pine, representing Saint Mary's; and James L. Wadhams, representing various interested parties. In addition, the Division received written comments from American Family Insurance and Anthem Blue Cross and Blue Shield.

Ms. Everett testified that the proposed regulation amends chapter 687B of the Nevada Administrative Code (NAC) to expand the Medicare supplement guaranteed issue requirements for standardized Medicare supplement plans to allow any pre-standardized policyholder to obtain a standardized policy and to ensure that senior citizen insureds do not lose policy benefits due to an unintentional lapse or termination in coverage, by allowing them to designate a third party to receive important notices.

Ms. Everett further testified that NAC 687B.250, 687B.311, and 687B.319 were amended by adding and deleting language to avoid future amendments to chapter 687B due to the annual changes in the Medicare supplement deductible rates. Double and triple asterisks are used in lieu

of the dollar amounts. The reader is directed to consult the most current version of the Guide to Health Insurance for People with Medicare.

In addition, language was added to NAC 687B.311 and 687B.319, plans F and J, to alert the reader to how changes in the deductible for these plans are calculated. By amending these sections, the Division hopes to eliminate the need to amend these sections on an annual basis. A revised version of the regulation is attached.

Considering the comments by those attending the workshop and hearing, and by those who submitted written comments, the Commissioner has issued an order adopting the regulation, as revised, pursuant to the workshop and hearing, as a permanent regulation of the Division.

Based upon the testimony received at the hearing, the proposed regulation is revised to read as follows:

1. Subsection 1 of section 2 is amended to read as follows:

> 1. Except as otherwise provided in subsection 2, an issuer shall, at the request of an insured, ***on a one time basis,*** replace a policy ***or a certificate*** to supplement Medicare ~~[or certificate]~~ which was issued before January 1, 1992, with any standardized benefit plan offered by the issuer.

2. Subsection 3 of section 2 is amended to read as follows:

> 3. If an insured requests a standardized benefit plan to replace a policy to supplement Medicare or certificate pursuant to subsection 1 from an issuer that establishes the rates of a standardized benefit plan on the basis of the age of an applicant on the date his application is submitted, the issuer must use the ***attained*** age of the insured at the time the policy to supplement Medicare or certificate ~~[was]~~ ***is*** issued to establish the rate for the standardized benefit plan.

3. Subsection 1(a) of section 5 is amended to read as follows:

> 1(a). Reinstatement is requested within ~~[5]~~ ***2*** months after the date of lapse of coverage; and

4. Delete subsection 2 of section 5.

The economic impact of the regulation is as follows:

(a) <u>On the business it is to regulate:</u> The industry will incur a nominal cost to add language to expand the Medicare supplement guaranteed issue requirements for standardized Medicare supplement plans to allow any pre-standardized policyholder to obtain a standardized policy and allow policyholders to designate a third party to receive important notices to avoid an unintentional lapse or termination in coverage.

(b) On the public: The regulation will have a negligible economic impact on the public.

The Division anticipates a nominal expense to enforce the proposed regulation.

The Division is not aware of any overlap or duplication of the regulation with any state, local or federal regulation.

STATE OF NEVADA
DEPARTMENT OF BUSINESS AND INDUSTRY
DIVISION OF INSURANCE

IN THE MATTER OF THE

CAUSE NO. **04.037**
LCB File No. **R027-04**

REGULATION REGARDING MEDICARE SUPPLEMENT POLICIES.

SUMMARY OF PROCEEDINGS AND ORDER

_____/

SUMMARY OF PROCEEDINGS

A public workshop, as required by NRS 233B.061, on the proposed regulation concerning Medicare supplement insurance policies was held before Cliff King, Chief Insurance Assistant, on March 23, 2004, in Carson City, Nevada, and video-conferenced to the Bradley Building in Las Vegas, Nevada. A public hearing on the proposed regulation was also held before Cliff King, Chief Insurance Assistant, on March 23, 2004, in Carson City, Nevada, and video-conferenced to the Bradley Building in Las Vegas, Nevada. The regulation is proposed under the authority of NRS 679B.130.

The Department of Business and Industry, Division of Insurance (Division), received written comments from American Family Insurance and Anthem Blue Cross and Blue Shield. These written comments were discussed during the workshop. The hearing was attended by 19 individuals. The following persons provided testimony before the Hearing Officer: Kimberly Everett, representing the Division; Carl Miller, representing Anthem Blue Cross and Blue Shield; Janice Pine, representing Saint Mary's; and James L. Wadhams, representing various interested parties.

Ms. Everett testified that the authority for this proposed regulation is NRS 679B.130. The proposed regulation amends chapter 687B of the Nevada Administrative Code (NAC) to expand the Medicare supplement guaranteed issue requirements for standardized Medicare

supplement plans to allow any pre-standardized policyholder to obtain a standardized policy and to ensure that senior citizen insureds do not lose policy benefits due to an unintentional lapse or termination in coverage, by allowing them to designate a third party to receive important notices.

NAC 687B.250, 687B.311, and 687B.319 were amended by adding and deleting language to avoid future amendments to chapter 687B due to the annual changes in the Medicare supplement deductible rates. Double and triple asterisks are used in lieu of the dollar amounts. The reader is directed to consult the most current version of the *Guide to Health Insurance for People with Medicare.*

Ms. Everett further testified that language was added to NAC 687B.311 and 687B.319, plans F and J, to alert the reader to how changes in the deductible for these plans are calculated. By amending these sections, the Division hopes to eliminate the need to amend these sections on an annual basis.

RECOMMENDED ORDER OF THE HEARING OFFICER

Based upon the written comments and testimony received at the hearing, it is recommended that the proposed regulation be revised to read as follows:

1. Subsection 1 of section 2 is amended to read as follows:

> 1. Except as otherwise provided in subsection 2, an issuer shall, at the request of an insured, ***on a one time basis,*** replace a policy ***or a certificate*** to supplement Medicare ~~[or certificate]~~ which was issued before January 1, 1992, with any standardized benefit plan offered by the issuer.

2. Subsection 3 of section 2 is amended to read as follows:

> 3. If an insured requests a standardized benefit plan to replace a policy to supplement Medicare or certificate pursuant to subsection 1 from an issuer that establishes the rates of a standardized benefit plan on the basis of the age of an applicant on the date his application is submitted, the issuer must use the ***attained*** age of the insured at the time the policy to supplement Medicare or certificate ~~[was]~~ ***is*** issued to establish the rate for the standardized benefit plan.

3. Subsection 1(a) of section 5 is amended to read as follows:

1(a). Reinstatement is requested within ~~[5]~~ ***2*** months after the date of lapse of coverage; and

4. Delete subsection 2 of section 5.

SO RECOMMENDED this _____ day of June, 2004.

_____
CLIFF KING, CPCU, ARM
Chief Insurance Assistant and Hearing Officer

ORDER OF THE COMMISSIONER

Having reviewed the record in this matter, it is hereby ordered that the proposed regulation regarding Medicare supplement insurance policies, LCB File No. R027-04, be adopted, as amended, as a permanent regulation of the Division.

SO ORDERED this _____ day of June, 2004.

_____
ALICE A. MOLASKY-ARMAN
Commissioner of Insurance