PROPOSED REGULATION OF THE DIVISION OF INSURANCE

OF THE DEPARTMENT OF BUSINESS AND INDUSTRY

LCB File No. R078-05

August 1, 2005

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

AUTHORITY: §§1-19, 21-25, 27-41, 46, NRS 679B.130, 687B.430; §§20, 26, NRS 679B.130, 687B.120, 687B.430; §§42-45, NRS 679B.130.

A REGULATION relating to policies supplementary to Medicare; revising various provisions related to such policies; 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 10, inclusive, of this regulation.

Sec. 2. ***"Creditable coverage" has the meaning ascribed to it in NRS 689A.505.***

Sec. 3. ***"Medicare Part D" means the prescription drug benefit created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173, 117 Stat. 2066, December 8, 2003, beginning January 1, 2006.***

Sec. 4. ***1. Eligible persons are those persons described in subsection 3 who seek to enroll under the policy during the period specified in section 5 of this regulation, and who submit evidence of the date of termination, disenrollment or Medicare Part D enrollment with the application for a policy to supplement Medicare.***

2. With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a policy to supplement Medicare described in section 7 of this regulation that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a policy to supplement Medicare because of health status, claims

experience, receipt of health care or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a policy to supplement Medicare.

3. An eligible person is a person described in any of the following paragraphs:

(a) The person is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the person;

(b) The person is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply, or the person is 65 years of age or older and is enrolled with a Program of All-inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act, 42 U.S.C. § 1395eee, and there are circumstances similar to those described below that would permit discontinuance of the person's enrollment with such provider if such person was enrolled in a Medicare Advantage plan:

(1) The certification of the organization or plan has been terminated;

(2) The organization has terminated or otherwise discontinued providing the plan in the area in which the person resides;

(3) The person is no longer eligible to elect the plan because of a change in the person's place of residence or other change in circumstances specified by the Secretary of the United States Department of Health and Human Services, but not including termination of the person's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act, 42 U.S.C. § 1395w-21(g)(3)(B), where the person has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section

1856 of the Social Security Act, 42 U.S.C. § 1395w-26, or the plan is terminated for all persons within a residence area;

(4) The person demonstrates, in accordance with guidelines established by the Secretary of the United States Department of Health and Human Services, that:

(I) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the person, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(II) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the person; or

(5) The person meets such other exceptional conditions as the Secretary of the United States Department of Health and Human Services may provide;

(c) The person is enrolled with:

(1) An eligible organization under a contract under section 1876 of the Social Security Act, 42 U.S.C. § 1395mm (Medicare cost);

(2) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(3) An organization under an agreement under section 1833(a)(1)(A) of the Social Security Act, 42 U.S.C. § 1395l(a)(1)(A) (health care prepayment plan); or

(4) An organization under a Medicare Select policy,

➥ and the enrollment ceases under the same circumstances that would permit discontinuance of a person's election of coverage under paragraph (b) of subsection 3;

(d) The person is enrolled under a policy to supplement Medicare and the enrollment ceases because:

(1) Of the insolvency of the issuer or bankruptcy of the nonissuer organization;

(2) Of other involuntary termination of coverage or enrollment under the policy;

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

(4) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the person;

(e) The person was enrolled under a policy to supplement Medicare and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, any eligible organization under a contract under section 1876 of the Social Security Act, 42 U.S.C. § 1395mm (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, 42 U.S.C. § 1395eee, or a Medicare Select policy, and the subsequent enrollment is terminated by the enrollee during any period within the first 12 months of such subsequent enrollment, during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the federal Social Security Act, 42 U.S.C. § 1395w-21(e);

(f) The person, upon first becoming eligible for benefits under Part A of Medicare at the age of 65 years, enrolls in a Medicare Advantage plan under Part C of Medicare, or with a PACE provider under section 1894 of the Social Security Act, 42 U.S.C. § 1395eee, and disenrolls from the plan or program by not later than 12 months after the effective date of enrollment; or

(g) The person enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a policy to supplement Medicare that covers outpatient prescription drugs, and the person terminates enrollment in the policy to supplement Medicare and submits evidence of enrollment in Medicare Part D along with the application for a policy described in subsection 5 of section 7 of this regulation.

Sec. 5. *1. In the case of a person described in paragraph (a) of subsection 3 of section 4 of this regulation, the guaranteed issue period begins on the later of:*

(a) The date the person receives a notice of termination or cessation of all supplemental health benefits, or, if a notice is not received, notice that a claim has been denied because of a termination or cessation; or

(b) The date that the applicable coverage terminates or ceases,

➥ and ends 63 days thereafter.

2. In the case of a person described in paragraph (b), (c), (e) or (f) of subsection 3 of section 4 of this regulation whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the person receives a notice of termination and ends 63 days after the date the applicable coverage is terminated.

3. In the case of a person described in subparagraph (1) of paragraph (d) of subsection 3 of section 4 of this regulation, the guaranteed issue period begins on the earlier of:

(a) The date that the person receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any; or

(b) The date that the applicable coverage is terminated,

➥ and ends on the date that is 63 days after the date the coverage is terminated.

4. In the case of a person described in paragraphs (b), (e) and (f), and subparagraphs (2) and (3) of paragraph (d), of subsection 3 of section 4 of this regulation who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date.

5. In the case of a person described in paragraph (g) of subsection 3 of section 4 of this regulation, the guaranteed issue period begins on the date the person receives notice pursuant to section 1882(v)(2)(B) of the Social Security Act, 42 U.S.C. § 1395ss(v)(2)(B), from the Medicare supplement issuer during the 60 day period immediately preceding the initial Medicare Part D enrollment period and ends on the date that is 63 days after the effective date of the person's coverage under Medicare Part D.

6. In the case of a person described in subsection 3 of section 4 of this regulation but not described in subsections 1 to 5, inclusive, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date.

7. A special enrollment period is available to persons who postpone enrollment in Medicare Part B until after the age of 65 years because they are working and are enrolled in a group health insurance plan. The special enrollment period for Medicare Part B may take place anytime through their or their spouse's current employment or during the 8 months following the month that the group health plan coverage of the employer or union ends or when the employment ends, whichever is first.

Sec. 6. *1. In the case of a person described in paragraph (e) of subsection 3 of section 4 of this regulation, or deemed to be so described pursuant to this subsection, whose enrollment with an organization or provider described in paragraph (e) of subsection 3 of section 4 of this regulation is involuntarily terminated within the first 12 months of enrollment, and who,*

without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph (e) of subsection 3 of section 4 of this regulation.

2. In the case of a person described in paragraph (f) of subsection 3 of section 4 of this regulation, or deemed to be so described, pursuant to this subsection, whose enrollment with a plan or in a program described in paragraph (f) of subsection 3 of section 4 of this regulation is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph (f) of subsection 3 of section 4 of this regulation.

3. For purposes of paragraphs (e) and (f) of subsection 3 of section 4 of this regulation, no enrollment of a person with an organization or provider described in paragraph (e) of subsection 3 of section 4 of this regulation, or with a plan or in a program described in paragraph (f) of subsection 3 of section 4 of this regulation, may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the person first enrolled with such an organization, provider, plan or program.

Sec. 7. *The policy to supplement Medicare to which eligible persons are entitled:*

1. Under paragraphs (a), (b), (c) and (d) of subsection 3 of section 4 of this regulation is a policy to supplement Medicare that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L offered by any issuer;

2. Subject to paragraph (e) of subsection 3 of section 4 of this regulation is the same policy to supplement Medicare in which the person was most recently and previously enrolled, if available from the same issuer, or, if not so available, a policy described in subsection 1;

3. After December 31, 2005, if the person was most recently enrolled in a policy to supplement Medicare with an outpatient prescription drug benefit, a policy to supplement Medicare described in this subsection is:

(a) The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or

(b) At the election of the policyholder, an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer;

4. Under paragraph (f) of subsection 3 of section 4 of this regulation shall include any policy to supplement Medicare offered by any issuer; or

5. Under paragraph (g) of subsection 3 of section 4 of this regulation is a policy to supplement Medicare that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the policy to supplement Medicare with outpatient prescription drug coverage.

Sec. 8. *1. At the time of an event described in subsection 3 of section 4 of this regulation because of which a person loses coverage or benefits because of the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy or the administrator of the plan being terminated, respectively, shall notify the person of his rights under this section, and of the obligations of issuers of policies to supplement Medicare under subsections 1 and 2 of section 4 of this regulation. Such notice must be communicated contemporaneously with the notification of termination.*

2. At the time of an event described in subsection 3 of section 4 of this regulation because of which a person ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy or the administrator of the plan, respectively, shall notify the person of his rights under this section, and of the obligations of issuers of policies to supplement Medicare under subsections 1 and 2 of section 4 of this regulation. Such notice must be communicated within 10 working days of the issuer receiving notification of disenrollment.

Sec. 9. *A benefit plan to supplement Medicare which is designated as Standardized Benefit Plan K must provide the following benefits:*

1. The benefits required by NAC 687B.290.

2. Coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subsection 8.

3. Coverage for 50 percent of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subsection 8.

4. Coverage for 50 percent of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subsection 8.

5. Coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first 3 pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subsection 8.

6. Except for coverage provided in subsection 8, coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in subsection 8.

7. Coverage of 100 percent of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible.

8. Coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the person has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of Health and Human Services.

Sec. 10. *A benefit plan to supplement Medicare which is designated as Standardized Benefit Plan L must provide the following benefits:*

1. The benefits required by NAC 687B.290.

2. Coverage for 75 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subsection 8.

3. Coverage for 75 percent of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subsection 8.

4. Coverage for 75 percent of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subsection 8.

5. Coverage for 75 percent, under Medicare Part A or B, of the reasonable cost of the first 3 pints of blood, or equivalent quantities of packed red blood cells, as defined under federal

regulations, unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subsection 8.

6. Except for coverage provided in subsection 8, coverage for 75 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in subsection 8.

7. Coverage of 100 percent of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible.

8. Coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the person has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $2,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of Health and Human Services.

Sec. 11. 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 10, inclusive, of this regulation,*** unless the context otherwise requires, the words and terms defined in NAC 687B.201 to 687B.2045, inclusive, ***and sections 2 and 3 of this regulation,*** have the meanings ascribed to them in those sections.

Sec. 12. NAC 687B.203 is hereby amended to read as follows:

687B.203 "Medicare ~~[+ Choice]~~ ***Advantage*** organization" has the meaning ascribed to it in section 1859(a)(1) of the Social Security Act, 42 U.S.C. § 1395w-28(a)(1).

Sec. 13. NAC 687B.2034 is hereby amended to read as follows:

687B.2034 "Medicare ~~[+ Choice]~~ ***Advantage*** plan" means a plan of coverage for health benefits under Medicare Part C, as defined in 42 U.S.C. §§ 1395w-28(b)(1), and includes:

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

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

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

(c) Preferred provider organization plans;

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

3. Medicare ~~[+ Choice]~~ ***Advantage*** private fee-for-service plans.

Sec. 14. NAC 687B.204 is hereby amended to read as follows:

687B.204 "Policy to supplement Medicare" means a group or individual policy of ~~[accident and sickness]~~ insurance, or a subscriber contract, other than a policy issued pursuant to section 1876 of the Social Security Act, 42 U.S.C. § 1395mm, or pursuant to a demonstration project that is advertised, marketed or designed primarily as a supplement to the reimbursements provided under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. ***The term does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under section 1833(a)(1)(A) of the Social Security Act, 42 U.S.C. § 1395l(a)(1)(A).***

Sec. 15. NAC 687B.2045 is hereby amended to read as follows:

687B.2045 "Standardized benefit plan" means a benefit plan to supplement Medicare that is designated as Standardized Benefit Plan A through ~~[J,]~~ ***L,*** inclusive, or High Deductible Benefit Plan F or J, as set forth in NAC 687B.300 to 687B.319, inclusive ~~[.]~~ ***, and sections 9 and 10 of this regulation.***

Sec. 16. NAC 687B.206 is hereby amended to read as follows:

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

(a) An employee welfare benefit plan that:

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

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

(b) An employee welfare benefit plan that:

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

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

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

(1) The certification of the organization or the plan has been terminated, or the organization or plan has notified the person of an impending termination of its certification.

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

(3) The person was no longer eligible to elect a ~~[Medicare + Choice]~~ ***Advantage*** plan because:

(I) His residence changed;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) The insurer involuntarily terminated coverage or enrollment;

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

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

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

3. A person who is eligible for a policy to supplement Medicare or a certificate pursuant to subsection 1 is entitled to obtain from any issuer a policy to supplement Medicare or a certificate that has a benefit plan that is designated as Standardized Benefit Plan A, B, C, F ~~[or High Deductible Benefit Plan F.]~~ ***(including F with a high deductible), K or L.***

4. ***After December 31, 2005, a person currently enrolled in a policy to supplement Medicare with an outpatient prescription drug benefit is eligible to:***

(a) Retain their current plan with outpatient prescription drug coverage;

(b) Enroll in a plan from the same issuer that is modified to exclude outpatient prescription drug coverage with the option to select Medicare Part D; or

(c) Enroll in an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer with an option to select Medicare Part D.

5. As used in this section, "Medicare select policy" has the meaning ascribed to it in NAC 687B.348.

Sec. 17. NAC 687B.2062 is hereby amended to read as follows:

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

(a) Disenrolled from such a policy or certificate;

(b) Subsequently enrolled for the first time in:

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

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

(3) Any PACE program; and

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

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

Sec. 18. NAC 687B.2064 is hereby amended to read as follows:

687B.2064 1. A person is eligible for a policy to supplement Medicare that is offered to new enrollees or for a certificate that is offered to new enrollees if he provides evidence that he has disenrolled within the previous 63 days from a Medicare ~~[+ Choice]~~ ***Advantage*** plan offered

by a Medicare ~~[+ Choice]~~ ***Advantage*** organization pursuant to Medicare Part C, or from a PACE program, if he:

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

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

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

Sec. 19. NAC 687B.209 is hereby amended to read as follows:

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

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

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

2. If the plan, certificate or policy was terminated, the notification required pursuant to subsection 1 must be provided with the notification of termination. If the person disenrolled from the plan, certificate or policy, the notification required pursuant to subsection 1 must be provided

within 10 working days after the issuer, insurer, Medicare ~~[+ Choice]~~ ***Advantage*** organization, eligible organization or Medicare select issuer received notification of the disenrollment.

3. As used in this section, "plan" means:

(a) A Medicare ~~[+ Choice]~~ ***Advantage*** plan;

(b) An employee welfare benefit plan; or

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

Sec. 20. NAC 687B.212 is hereby amended to read as follows:

687B.212 1. An issuer shall not deliver or issue for delivery in this State a policy to supplement Medicare or a certificate unless the policy form or certificate form has been filed with and approved by the Commissioner pursuant to NRS 687B.120.

2. ***An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173, 117 Stat. 2066, December 8, 2003, with the commissioner in the state in which the policy or certificate was issued.***

3. Except as otherwise provided in this subsection, an issuer shall not file for approval more than one policy form or certificate form for each type of policy in a standardized benefit plan to supplement Medicare. An issuer may offer, with the approval of the Commissioner, not more than four additional forms for the same type of policy in a standardized benefit plan to supplement Medicare:

(a) For the inclusion of new or innovative benefits;

(b) For the addition of a direct-response or agent-marketing method;

(c) For the addition of guaranteed issue or underwritten coverage; or

(d) To offer coverage to persons eligible for Medicare because of a disability.

~~[3.]~~ ***4.*** For the purposes of this section:

(a) "Type of policy" means an individual or group policy.

(b) A policy issued as a result of any solicitation made by mail or by advertising using the mass media, including any written or broadcasted advertisement, shall be deemed to be an individual policy.

Sec. 21. NAC 687B.215 is hereby amended to read as follows:

687B.215 1. Each policy to supplement Medicare or certificate advertised, solicited or issued for delivery in this State must contain definitions or terms conforming to the requirements of this section.

2. "Accident," "accidental injury" or "accidental means" must be defined to employ "result" language and may not include words that establish an accidental means test or use words such as "external," "violent," "visible wounds" or similar words of description or characterization. The definition:

(a) May not define the terms more restrictively than as the direct result of an accident, independent of disease or bodily infirmity or any other cause, that occurs while insurance coverage is in force.

(b) Unless prohibited by law, may provide that the terms do not include any injury for benefits which are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan.

3. "Benefit period" or "Medicare benefit period" may not be defined more restrictively than as defined by Medicare.

4. “Convalescent nursing home,” “extended care facility” or “skilled nursing facility” may not be defined more restrictively than as defined by Medicare.

5. “Health care expenses” means the expenses of a health maintenance organization associated with the delivery of services for health care that are analogous to the incurred losses of an issuer. ~~[The term may not include:~~

~~(a) Home office and overhead costs;~~

~~(b) Costs of advertising;~~

~~(c) Commissions and other costs of acquisition;~~

~~(d) Taxes;~~

~~(e) Capital costs;~~

~~(f) Costs of administration; or~~

~~(g) Costs for the processing of claims.]~~

6. “Hospital” may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals. The definition must not be more restrictive than as defined by Medicare.

7. “Medicare” must be defined in the policy and certificate. The term may be defined as “The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended,” or “Title I, Part I of Public Law 89-97, as enacted by the 89th Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof,” or words of similar import.

8. “Medicare eligible expenses” means expenses for health care of the kinds covered by Medicare ~~[,]~~ ***Parts A and B,*** to the extent recognized as reasonable and medically necessary by Medicare.

9. “Physician” may not be defined more restrictively than as defined by Medicare.

10. Except as otherwise provided in this subsection, “sickness” must not be defined more restrictively than the following:

> “Sickness” means an illness or disease of an insured person that first manifests itself after the effective date of insurance and while the insurance is in force.

The definition may be modified to exclude sicknesses or diseases for which benefits are provided under any workers’ compensation, occupational disease, employer’s liability or similar law.

Sec. 22. NAC 687B.220 is hereby amended to read as follows:

687B.220 1. Except as otherwise provided in paragraphs (a) and (b) of subsection 2 of NAC 687B.226 and paragraphs (a) and (b) of subsection 2 of NAC 687B.227, a policy or certificate may not be advertised, solicited or issued for delivery in this State as a policy to supplement Medicare if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

2. A policy to supplement Medicare or a certificate must not use a waiver to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

3. A policy to supplement Medicare or a certificate must not contain benefits that duplicate the benefits provided by Medicare.

4. A policy to supplement Medicare with benefits for outpatient prescription drugs in existence before January 1, 2006 must be renewed for current policyholders who do not enroll in Medicare Part D at the option of the policyholder.

5. A policy to supplement Medicare with benefits for outpatient prescription drugs must not be issued after December 31, 2005.

6. After December 31, 2005, a policy to supplement Medicare with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part D unless:

(a) The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the person's coverage under a Medicare Part D plan; and

(b) Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

Sec. 23. NAC 687B.225 is hereby amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) Coverage under Medicare Part A for the reasonable cost of the first 3 pints of blood, or an equivalent quantity of packed red blood cells, as defined by federal regulations, unless replaced in accordance with federal regulations or already paid for pursuant to Part B. ***Plans K and L provide for 50 percent and 75 percent coverage of the cost, respectively.***

(f) Coverage for the coinsurance amount, or, for services from a hospital outpatient department paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount that is equal to the Medicare Part B deductible of ~~[$100.]~~ ***$110.***

(g) Coverage under Medicare Part B for the reasonable cost of the first 3 pints of blood, or equivalent quantities of packed red blood cells, as defined by federal regulations, unless replaced in accordance with federal regulations or already paid for pursuant to Part A, subject to the Medicare deductible amount. ***Plans K and L provide for 50 percent and 75 percent coverage of the cost, respectively.***

7. For the purposes of this section:

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

(b) "Policy to supplement Medicare" means a group or individual policy of accident and sickness insurance, or a subscriber contract of one or more hospital and medical service associations or health maintenance organizations, that is advertised, marketed or designed primarily as a supplement to the reimbursement provided under Medicare for the hospital, medical or surgical expenses of one or more persons eligible for Medicare by reason of age.

Sec. 24. NAC 687B.226 is hereby amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8. If a group policy to supplement Medicare or a certificate is replaced by another group policy to supplement Medicare or another certificate which is purchased by the same person, the issuer of the replacement policy or certificate shall offer coverage to all persons who are covered under the policy or certificate that is being replaced on the date it is terminated. The replacement policy or certificate may not provide for the exclusion of coverage for preexisting conditions that were covered under the policy or certificate that is being replaced.

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

any, or to payment of the maximum benefits. ***Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.***

10. ***If a policy to supplement Medicare eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173, 117 Stat. 2066, December 8, 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this section.***

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

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

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

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

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

(e) Coverage under Medicare Part A for the reasonable cost of the first 3 pints of blood, or an equivalent quantity of packed red blood cells, as defined by federal regulations, unless replaced in accordance with federal regulations or already paid for pursuant to Part B. ***Plans K and L provide for 50 percent and 75 percent of the cost, respectively.***

(f) Coverage for the coinsurance amount, or, for services from a hospital outpatient department paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount that is equal to the Medicare Part B deductible of ~~[$100.]~~ ***$110.*** This coverage must include coverage for Medicare eligible expenses for drugs used by an outpatient for immune suppressive therapy.

(g) Coverage under Medicare Part B for the reasonable cost of the first 3 pints of blood, or equivalent quantities of packed red blood cells, as defined by federal regulations, unless replaced in accordance with federal regulations or already paid for pursuant to Part A, subject to the Medicare deductible amount. ***Plans K and L provide for 50 percent and 75 percent of the coverage of the cost, respectively.***

Sec. 25. NAC 687B.227 is hereby amended to read as follows:

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

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

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

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

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

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

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

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

6. Termination of a policy to supplement Medicare or a certificate must be without prejudice to any continuous loss that commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, and limited to the duration of the policy benefit period, if any, or to the payment of the maximum benefits. ***Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.***

7. Benefits and premiums must be suspended at the request of the policyholder or certificate holder for the period, not to exceed 24 months, during which the holder has applied for and is determined to be eligible for medical assistance under Title XIX of the Social Security Act, 42

U.S.C. §§ 1396 et seq., if the holder notifies the issuer of the policy or certificate within 90 days after the date he becomes eligible for such assistance.

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

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

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

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

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

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

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

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

Sec. 26. NAC 687B.230 is hereby amended to read as follows:

687B.230 1. A policy to supplement Medicare or a certificate must not be delivered or issued for delivery in this State unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to the policyholder or certificate holder the following amounts in the form of aggregate benefits provided under the policy, not including anticipated refunds or credits:

(a) In the case of a group policy, at least 75 percent of the aggregate amount of premiums earned.

(b) In the case of an individual policy, at least 65 percent of the aggregate amount of premiums earned. For the purposes of this paragraph, a policy issued as a result of any solicitation made by mail or by advertising using the mass media, including any written or broadcasted advertisement, shall be deemed to be an individual policy.

➥ The aggregate benefits must be calculated on the basis of incurred claims experience or incurred expenses for health care if coverage is provided by a health maintenance organization on the basis of payments made to the provider of health care rather than reimbursements made to the insured, and must be calculated in accordance with accepted actuarial principles and practices. ***Incurred health care expenses where coverage is provided by a health maintenance organization must not include:***

(1) Home office and overhead costs;

(2) Advertising costs;

(3) Commissions and other acquisition costs;

(4) Taxes;

(5) Capital costs;

(6) Administrative costs; and

(7) Claims processing costs.

2. All filings of rates and rating schedules must demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience as of the date of the filing. Filing of revisions of rates must also demonstrate that the anticipated loss ratio during the period for which the revised rates are computed can be expected to meet the appropriate standards for the loss ratio.

3. Each issuer providing a policy to supplement Medicare or a certificate in this State shall file annually with the Division its rates, rating schedule and supporting documentation, including ratios of incurred losses to earned premiums by policy duration, for approval by the Commissioner. The supporting documentation must:

(a) Demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate standards for loss ratios can be expected to be met during the entire period for which the rates are computed; and

(b) Exclude active life reserves.

➥ An expected third-year loss ratio that is greater than or equal to the applicable percentage must be demonstrated for policies to supplement Medicare or certificates in force less than 3 years.

4. As soon as practicable before the effective date of any enhancements to Medicare benefits, every issuer shall file with the Division in accordance with NRS 687B.120:

(a) Appropriate adjustments of premiums necessary to produce loss ratios as anticipated for the current premiums for the applicable policies or certificates, together with such supporting documents as are necessary to justify the adjustment; and

(b) Any appropriate riders, endorsements or policy forms needed to accomplish the modifications to the policy to supplement Medicare or the certificate which are necessary to eliminate any duplication of Medicare benefits. Any such riders, endorsements or policy forms must provide a clear description of the benefits to supplement Medicare that are provided by the policy or certificate.

5. An issuer shall make such adjustments to premiums pursuant to paragraph (a) of subsection 4 as are necessary to produce an expected loss ratio that conforms to the minimum standards for loss ratios for policies to supplement Medicare or certificates which are expected to result in a loss ratio that is at least as great as the ratio originally anticipated for the rates used by the issuer to calculate current premiums for the policy to supplement Medicare or the certificate. An adjustment to premiums which modifies the loss ratio, other than an adjustment made pursuant to this section, may not be made at any time other than upon the renewal of the policy or certificate or its anniversary date. If an issuer makes an adjustment to premiums which is not acceptable to the Commissioner, the Commissioner may order an adjustment to premiums, a refund or a credit which he deems necessary to achieve the loss ratio required by this section.

6. The Commissioner may conduct a hearing to obtain information concerning a request submitted by an issuer for an increase in the rates for a policy to supplement Medicare or a certificate if the experience incurred during the reporting period does not comply with the applicable standard for loss ratios. The Commissioner will determine whether the experience

complies with the applicable standard without considering any refund or credit required for the reporting period.

7. The provisions of this section apply to any policy to supplement Medicare or any certificate delivered or issued for delivery in this State, regardless of the date of its delivery or issuance.

Sec. 27. 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 7.

4. Standardized Benefit Plans A through ~~[J,]~~ ***L,*** 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.]~~ ***of the Standard Medicare Supplement Plans.***
Every company must make available Plan "A."

See Outlines of Coverage sections for details about ALL plans.

BASIC BENEFITS ~~[: Included in All Plans.]~~ ***for Plans A-J, inclusive:***
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.]~~ ***copayments for hospital outpatient services.***
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. 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.

(COMPANY NAME)

Outline of Medicare Supplement Coverage-Cover Page 2

Basic Benefits for Plans K and L include similar services as plans A-J, inclusive, but cost-sharing for the basic benefits is at different levels.

	K**	***L*****
Basic Benefits	***100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End*** ***50% Hospice cost-sharing*** ***50% of Medicare-eligible expenses for the first three pints of blood*** ***50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services***	***100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End*** ***75% Hospice cost-sharing*** ***75% of Medicare-eligible expenses for the first three pints of blood*** ***75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services***
Skilled Nursing Coinsurance	***50% Skilled Nursing Facility Coinsurance***	***75% Skilled Nursing Facility Coinsurancee***
Part A Deductible	***50% Part A Deductible***	***75% Part A Deductible***
Part B Deductible		
Part B Excess (100%)		

Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	$4,000 Out of Pocket Annual Limit***	***$2,000 Out of Pocket Annual Limit******

***** Plans K and L provide for different cost-sharing for items and services than Plans A-J, inclusive.***
Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges." You will be responsible for paying excess charges.
****** The out-of-pocket annual limit will increase each year for inflation.***
See Outlines of Coverage for details and exceptions.

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 61st thru 90th day 91st day and after: While using 60 lifetime reserve days Once lifetime reserve days are used: Additional 365 days Beyond the additional 365 days	 ** ** ** $0 $0	 $0 *** *** 100% of Medicare Eligible Expenses $0	 **** (Part A Deductible) $0 $0 $0 All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	 All approved amounts ** $0	 $0 $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

PLAN A

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

* Once you have been billed ~~[$100]~~ ***$110*** 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]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts ~~[Part B excess charges (above Medicare-approved amounts)]~~	 $0 ***Generally*** 80% ~~[$0]~~	 $0 ***Generally*** 20% ~~[$0]~~	 ~~[$100]~~ ***$110*** (Part B Deductible) $0 ~~[All costs]~~
Part B Excess Charges (Above Medicare-approved amounts)	***$0***	***$0***	***All costs***

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints Next ~~[$100]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 ~~[$100]~~ ***$110*** (Part B Deductible) $0
CLINICAL LABORATORY SERVICES - ~~[BLOOD]~~ TESTS FOR DIAGNOSTIC SERVICES	 100%	 $0	 $0

PARTS A & B

* Once you have been billed ~~[$100]~~ ***$110*** 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 Durable medical equipment: First ~~[$100]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts	 100% $0 80%	 $0 $0 20%	 $0 ~~[$100]~~ ***$110*** (Part B Deductible) $0

PLAN B

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 consecutive days.

** 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 61st thru 90th day 91st day and after: While using 60 lifetime reserve days Once lifetime reserve days are used: Additional 365 days Beyond the additional 365 days	 ** ** ** $0 $0	 *** (Part A Deductible) *** *** 100% of Medicare Eligible Expenses $0	 $0 $0 $0 $0 All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	 All approved amounts ** $0	 $0 $0 $0	 $0 **** All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN B

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

* Once you have been billed ~~[$100]~~ ***$110*** 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]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts ~~[Part B excess charges (above Medicare-approved amounts)]~~	 $0 ***Generally*** 80% ~~[$0]~~	 $0 ***Generally*** 20% ~~[$0]~~	 ~~[$100]~~ ***$110*** (Part B Deductible) $0 ~~[All costs]~~
Part B Excess Charges (Above Medicare-approved amounts)	***$0***	***$0***	***All costs***
BLOOD First 3 pints Next ~~[$100]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 ~~[$100]~~ ***$110*** (Part B Deductible) $0
CLINICAL LABORATORY SERVICES - ~~[BLOOD]~~ TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

* Once you have been billed ~~[$100]~~ ***$110*** 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 Durable medical equipment: First ~~[$100]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts	 100% $0 80%	 $0 $0 20%	 $0 ~~[$100]~~ ***$110*** (Part B Deductible) $0

PLAN C

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 consecutive days.

** 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 61st thru 90th day 91st day and after: While using 60 lifetime reserve days Once lifetime reserve days are used: Additional 365 days Beyond the additional 365 days	 ** ** ** $0 $0	 *** (Part A Deductible) *** *** 100% of Medicare Eligible Expenses $0	 $0 $0 $0 $0 All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	 All approved amounts ** $0	 $0 *** $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

PLAN C

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

* Once you have been billed ~~[$100]~~ ***$110*** 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]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts ~~[Part B excess charges (above Medicare-approved amounts)]~~	 $0 ***Generally*** 80% ~~[$0]~~	 ~~[$100]~~ ***$110*** (Part B Deductible) ***Generally*** 20% ~~[$0]~~	 $0 $0 ~~[All costs]~~
Part B Excess Charges (Above Medicare-approved amounts)	***$0***	***$0***	***All costs***

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints Next ~~[$100]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts	 $0 $0 80%	 All costs ~~[$100]~~ ***$110*** (Part B Deductible) 20%	 $0 $0 $0
CLINICAL LABORATORY SERVICES - ~~[BLOOD]~~ TESTS FOR DIAGNOSTIC SERVICES	 100%	 $0	 $0

PARTS A & B

* Once you have been billed ~~[$100]~~ ***$110*** 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 Durable medical equipment: First ~~[$100]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts	 100% $0 80%	 $0 ~~[$100]~~ ***$110*** (Part B Deductible) 20%	 $0 $0 $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 Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum

PLAN D

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 consecutive days.

** 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 61st thru 90th day 91st day and after: While using 60 lifetime reserve days Once lifetime reserve days are used: Additional 365 days Beyond the additional 365 days	 ** ** ** $0 $0	 *** (Part A Deductible) *** *** 100% of Medicare Eligible Expenses $0	 $0 $0 $0 $0 All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	 All approved amounts ** $0	 $0 *** $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

PLAN D

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

* Once you have been billed ~~[$100]~~ ***$110*** 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]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts ~~[Part B excess charges (above Medicare-approved amounts)]~~	 $0 ***Generally*** 80% ~~[$0]~~	 $0 ***Generally*** 20% ~~[$0]~~	 ~~[$100]~~ ***$110*** (Part B Deductible) $0 ~~[All costs]~~
Part B Excess Charges (Above Medicare-approved amounts)	***$0***	***$0***	***All costs***
BLOOD First 3 pints Next ~~[$100]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 ~~[$100]~~***$110*** (Part B Deductible) $0
CLINICAL LABORATORY SERVICES - ~~[BLOOD]~~ TESTS FOR DIAGNOSTIC SERVICES	~~[$100]~~ ***100%***	$0	$0

PARTS A & B

* Once you have been billed ~~[$100]~~ ***$110*** 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 Durable medical equipment: First ~~[$100]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts	~~[$100]~~ ***100%*** $0 80%	$0 $0 20%	$0 ~~[$100]~~ ***$110*** (Part B Deductible) $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 61st thru 90th day 91st day and after: While using 60 lifetime reserve days Once lifetime reserve days are used: Additional 365 days Beyond the additional 365 days	 ** ** ** $0 $0	 *** (Part A Deductible) *** *** 100% of Medicare Eligible Expenses $0	 $0 $0 $0 $0 All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	 All approved amounts ** $0	 $0 *** $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

PLAN E

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

* Once you have been billed ~~[$100]~~ ***$110*** 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]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts ~~[Part B excess charges (above Medicare-approved amounts)]~~	 $0 ***Generally*** 80% ~~[$0]~~	 $0 ***Generally*** 20% ~~[$0]~~	 ~~[$100]~~ ***$110*** (Part B Deductible) $0 ~~[All costs]~~
Part B Excess Charges (Above Medicare-approved amounts)	***$0***	***$0***	***All costs***
BLOOD First 3 pints Next ~~[$100]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 ~~[$100]~~ ***$110*** (Part B Deductible) $0
CLINICAL LABORATORY SERVICES - ~~[BLOOD]~~ TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

* Once you have been billed ~~[$100]~~ ***$110*** 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 Durable medical equipment: First ~~[$100]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts	 100% $0 80%	 $0 $0 20%	 $0 ~~[$100]~~ ***$110*** (Part B Deductible) $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 Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum
PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE* Some annual physical and preventive tests and services ~~[such as digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education,]~~ administered or ordered by your doctor when not covered by Medicare: First $120 each calendar year Additional charges	 $0 $0	 $120 $0	 $0 All costs

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 61st thru 90th day 91st day and after: While using 60 lifetime reserve days Once lifetime reserve days are used: Additional 365 days Beyond the additional 365 days	 ** ** ** $0 $0	 *** (Part A Deductible) *** *** 100% of Medicare Eligible Expenses $0	 $0 $0 $0 $0 All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	 All approved amounts ** $0	 $0 *** $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

PLAN F

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

* Once you have been billed ~~[$100]~~ ***$110*** 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]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts ~~[Part B excess charges (above Medicare-approved amounts)]~~	 $0 ***Generally*** 80% ~~[$0]~~	 ~~[$100]~~ ***$110*** (Part B Deductible) ***Generally*** 20% ~~[100%]~~	 $0 $0 ~~[$0]~~
Part B Excess Charges (Above Medicare-approved amounts)	***$0***	***100%***	***$0***
BLOOD First 3 pints Next ~~[$100]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts	 $0 $0 80%	 All costs ~~[$100]~~ ***$110*** (Part B Deductible) 20%	 $0 $0 $0
CLINICAL LABORATORY SERVICES - ~~[BLOOD]~~ TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

* Once you have been billed ~~[$100]~~ ***$110*** 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 Durable medical equipment: First ~~[$100]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts	 100% $0 80%	 $0 ~~[$100]~~ ***$110*** (Part B Deductible) 20%	 $0 $0 $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 Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum

HIGH DEDUCTIBLE BENEFIT PLAN F

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 consecutive days.

** 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. 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 DEDUCTIBLE PLAN PAYS****	IN ADDITION TO THE DEDUCTIBLE YOU PAY****
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61st thru 90th day 91st day and after: While using 60 lifetime reserve days Once lifetime reserve days are used: Additional 365 days Beyond the additional 365 days	 ** ** ** $0 $0	 *** (Part A Deductible) *** *** 100% of Medicare Eligible Expenses $0	 $0 $0 $0 $0 All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	 All approved amounts ** $0	 $0 *** $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]~~ ***$110*** 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]~~ ***$110*** 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 DEDUCTIBLE PLAN PAYS**	IN ADDITION TO THE 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]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts ~~[Part B excess charges (above Medicare-approved amounts)]~~	 $0 ***Generally*** 80% ~~[$0]~~	 ~~[$100]~~ ***$110*** (Part B Deductible) ***Generally*** 20% ~~[100%]~~	 $0 $0 ~~[$0]~~
Part B Excess Charges (Above Medicare-approved amounts)	***$0***	***100%***	***$0***
BLOOD First 3 pints Next ~~[$100]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts	 $0 $0 80%	 All costs ~~[$100]~~ ***$110*** (Part B Deductible) 20%	 $0 $0 $0
CLINICAL LABORATORY SERVICES - ~~[BLOOD]~~ TESTS FOR DIAGNOSTIC SERVICES	 100%	 $0	 $0

HIGH DEDUCTIBLE BENEFIT PLAN F

MEDICARE (PARTS A & B)

* Once you have been billed ~~[$100]~~ ***$110*** 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]~~ ***$110*** 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 DEDUCTIBLE PLAN PAYS**	IN ADDITION TO THE DEDUCTIBLE YOU PAY**
HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment: First ~~[$100]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts	 100% $0 80%	 $0 ~~[$100]~~ ***$110*** (Part B Deductible) 20%	 $0 $0 $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 DEDUCTIBLE PLAN PAYS*	IN ADDITION TO THE 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 Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum

PLAN G

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 consecutive days.

** 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 61st thru 90th day 91st day and after: While using 60 lifetime reserve days Once lifetime reserve days are used: Additional 365 days Beyond the additional 365 days	 ** ** ** $0 $0	 *** (Part A Deductible) *** *** 100% of Medicare Eligible Expenses $0	 $0 $0 $0 $0 All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	 All approved amounts ** $0	 $0 *** $0	 $0 $0 All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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

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

* Once you have been billed ~~[$100]~~ ***$110*** 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]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts ~~[Part B excess charges (above Medicare-approved amounts)]~~	 $0 ***Generally*** 80% ~~[$0]~~	 $0 ***Generally*** 20% ~~[80%]~~	 ~~[$100]~~ ***$110*** (Part B Deductible) $0 ~~[20%]~~
Part B Excess Charges (Above Medicare-approved amounts)	***$0***	***80%***	***20%***
BLOOD First 3 pints Next ~~[$100]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 ~~[$100]~~ ***$110*** (Part B Deductible) $0
CLINICAL LABORATORY SERVICES - ~~[BLOOD]~~ TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN G

PARTS A & B

* Once you have been billed ~~[$100]~~ ***$110*** 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 Durable medical equipment: First ~~[$100]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts	 100% $0 80%	 $0 $0 20%	 $0 ~~[$100]~~ ***$110*** (Part B Deductible) $0

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

PLAN G

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 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 61st thru 90th day 91st day and after: While using 60 lifetime reserve days Once lifetime reserve days are used: Additional 365 days Beyond the additional 365 days	** ** ** $0 $0	*** (Part A Deductible) *** *** 100% of Medicare Eligible Expenses $0	$0 $0 $0 $0 All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 ** $0	 $0 *** $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

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

* Once you have been billed ~~[$100]~~ ***$110*** 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]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts ~~[Part B excess charges (above Medicare-approved amounts)]~~	 $0 ***Generally*** 80% ~~[$0]~~	 $0 ***Generally*** 20% ~~[$0]~~	 ~~[$100]~~ ***$110*** (Part B Deductible) $0 ~~[All costs]~~
Part B Excess Charges (Above Medicare-approved amounts)	***$0***	***$0***	***All costs***
BLOOD First 3 pints Next ~~[$100]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 ~~[$100]~~ ***$110*** (Part B Deductible) $0
CLINICAL LABORATORY SERVICES - ~~[BLOOD]~~ TESTS FOR DIAGNOSTIC SERVICES	 100%	 $0	 $0

PLAN H

PARTS A & B

* Once you have been billed ~~[$100]~~ ***$110*** 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 Durable medical equipment: First ~~[$100]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% $0 80%	$0 $0 20%	$0 ~~[$100]~~ ***$110*** (Part B Deductible) $0

OTHER BENEFITS - NOT COVERED BY MEDICARE

Note: A policy to supplement Medicare with benefits for outpatient prescription drugs in existence before January 1, 2006, must be renewed for current policyholders who do not enroll in Medicare Part D at the option of the policyholder.

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

PLAN I

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 consecutive days.

** 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 61st thru 90th day 91st day and after: While using 60 lifetime reserve days Once lifetime reserve days are used: Additional 365 days Beyond the additional 365 days	 ** ** ** $0 $0	 *** (Part B Deductible) *** *** 100% of Medicare Eligible Expenses $0	 $0 $0 $0 $0 All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 ** $0	 $0 *** $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

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

* Once you have been billed ~~[$100]~~ ***$110*** 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]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts ~~[Part B excess charges (above Medicare-approved amounts)]~~	 $0 ***Generally*** 80% ~~[$0]~~	 $0 ***Generally*** 20% ~~[100%]~~	 ~~[$100]~~ ***$110*** (Part B Deductible) $0 ~~[$0]~~
Part B Excess Charges (Above Medicare-approved amounts)	***$0***	***100%***	***$0***
BLOOD First 3 pints Next ~~[$100]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 ~~[$100]~~ ***$110*** (Part B Deductible) $0
CLINICAL LABORATORY SERVICES - ~~[BLOOD]~~ TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN I

PARTS A & B

* Once you have been billed ~~[$100]~~ ***$110*** 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 Durable medical equipment: First ~~[$100]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% $0 80%	$0 $0 20%	$0 ~~[$100]~~ ***$110*** (Part B Deductible) $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

OTHER BENEFITS - ***NOT COVERED BY MEDICARE***

Note: A policy to supplement Medicare with benefits for outpatient prescription drugs in existence before January 1, 2006, must be renewed for current policyholders who do not enroll in Medicare Part D at the option of the policyholder.

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

PLAN J

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 consecutive days.

** 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 61st thru 90th day 91st day and after: While using 60 lifetime reserve days Once lifetime reserve days are used: Additional 365 days Beyond the additional 365 days	 ** ** ** $0 $0	 *** (Part A Deductible) *** *** 100% of Medicare Eligible Expenses $0	 $0 $0 $0 $0 All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	 All approved amounts ** $0	 $0 *** $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

PLAN J

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

* Once you have been billed ~~[$100]~~ ***$110*** 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]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts ~~[Part B excess charges (above Medicare-approved amounts)]~~	 $0 ***Generally*** 80% ~~[$0]~~	 ~~[$100]~~ ***$110*** (Part B Deductible) ***Generally*** 20% ~~[100%]~~	 $0 $0 ~~[$0]~~
Part B Excess Charges (Above Medicare-approved amounts)	***$0***	***100%***	***$0***
BLOOD First 3 pints Next ~~[$100]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts	 $0 $0 80%	 All costs ~~[$100]~~ ***$110*** (Part B Deductible) 20%	 $0 $0 $0
CLINICAL LABORATORY SERVICES - ~~[BLOOD]~~ TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

* Once you have been billed ~~[$100]~~ ***$110*** 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 Durable medical equipment: First ~~[$100]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts	 100% $0 80%	 $0 ~~[$100]~~ ***$110*** (Part B Deductible) 20%	 $0 $0 $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 J

OTHER BENEFITS ***- NOT COVERED BY MEDICARE***

* 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.

Note: A policy to supplement Medicare with benefits for outpatient prescription drugs in existence before January 1, 2006, must be renewed for current policyholders who do not enroll in Medicare Part D at the option of the policyholder.

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

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

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

* Once you have been billed ~~[$100]~~ ***$110*** 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]~~ ***$110*** 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. 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 DEDUCTIBLE PLAN PAYS**	IN ADDITION TO THE 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]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts ~~[Part B excess charges (above Medicare-approved amounts)]~~	 $0 ***Generally*** 80% ~~[$0]~~	 ~~[$100]~~ ***$110*** (Part B Deductible) 20% ~~[100%]~~	 $0 $0 ~~[$0]~~
Part B Excess Charges (Above Medicare-approved amounts)	***$0***	***100%***	***$0***
BLOOD First 3 pints Next ~~[$100]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts	 $0 $0 80%	 All costs ~~[$100]~~ ***$110*** (Part B Deductible) 20%	 $0 $0 $0
CLINICAL LABORATORY SERVICES - ~~[BLOOD]~~ TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE BENEFIT PLAN J

MEDICARE (PARTS A & B)

* Once you have been billed ~~[$100]~~ ***$110*** 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]~~ ***$110*** 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 DEDUCTIBLE PLAN PAYS**	IN ADDITION TO THE DEDUCTIBLE YOU PAY**
HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment: First ~~[$100]~~ ***$110*** of Medicare-approved amounts* Remainder of Medicare-approved amounts	 100% $0 80%	 $0 ~~[$100]~~ ***$110*** (Part B Deductible) 20%	 $0 $0 $0
HOME HEALTH CARE AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan: Benefit for each visit Number of visits covered (must be received within 8 weeks of last Medicare-approved visit) Calendar year maximum	 $0 $0 $0	 Actual charges to $40 a visit Up to the number of Medicare-approved visits, not to exceed seven each week $1,600	 Balance

HIGH DEDUCTIBLE BENEFIT PLAN J

OTHER BENEFITS ***- NOT COVERED BY MEDICARE***

* 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.

Note: A policy to supplement Medicare with benefits for outpatient prescription drugs in existence before January 1, 2006, must be renewed for current policyholders who do not enroll in Medicare Part D at the option of the policyholder.

SERVICES	MEDICARE PAYS	AFTER YOU PAY THE DEDUCTIBLE PLAN PAYS*	IN ADDITION TO THE 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 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[

SERVICES	MEDICARE PAYS	AFTER YOU PAY THE DEDUCTIBLE PLAN PAYS*	IN ADDITION TO THE DEDUCTIBLE YOU PAY*
~~[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

PLAN K

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

**** You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $4,000 each calendar year.***

◆ The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coninsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

***** 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.***

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY**
HOSPITALIZATION** ***Semiprivate room and board, general nursing and miscellaneous services and supplies:*** ***First 60 days*** ***61st thru 90th day*** ***91st day and after:*** ***While using 60 lifetime reserve days*** ***Once lifetime reserve days are used:*** ***Additional 365 days*** ***Beyond the additional 365 days***	 *** *** *** *$0* *$0*	 *** (50% of Part A Deductible) *** *** *100% of Medicare Eligible Expenses* *$0*	 *** (50% of Part A Deductible) ◆ *$0* *$0* *$0* *All costs*
SKILLED NURSING FACILITY CARE** ***You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:*** ***First 20 days*** ***21st thru 100th day*** ***101st day and after***	 *All approved amounts* *** *$0*	 *$0* *** *$0*	 *$0* *** ◆ *All costs*

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY**
BLOOD *First 3 pints* *Additional amounts*	 *$0* *100%*	 *50%* *$0*	 *50% ◆* *$0*
HOSPICE CARE *Available as long as your doctor certifies you are terminally ill and you elect to receive these services*	*Generally, most Medicare eligible expenses for out-patient drugs and inpatient respite care*	*50% of coinsurance or copayments*	*50% of coinsurance or copayments ◆*

PLAN K

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

** Once you have been billed $110 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.*

◆◆ This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $4,000 per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

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 $110 of Medicare-approved amounts**	*$0*	*$0*	*$110 (Part B Deductible) ◆*
Preventive Benefits for Medicare covered services	*Generally 75% or more of Medicare-approved amounts*	*Remainder of Medicare-approved amounts*	*All costs above Medicare-approved amounts*
Remainder of Medicare-approved amounts	*Generally 80%*	*Generally 10%*	*Generally 10% ◆*
Part B Excess Charges (Above Medicare-approved amounts) ◆◆	*$0*	*$0*	*All costs*
BLOOD *First 3 pints* *Next $110 of Medicare-approved amounts**	 *$0* *$0*	 *50%* *$0*	 *50% ◆* *$110 (Part B Deductible) ◆*
Remainder of Medicare-approved amounts	*Generally 80%*	*Generally 10%*	*Generally 10% ◆*
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	*100%*	*$0*	*$0*

PARTS A & B

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

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY***
HOME HEALTH CARE *MEDICARE-APPROVED SERVICES* *Medically necessary skilled care services and medical supplies* *Durable medical equipment:* *First $110 of Medicare-approved amounts*** *Remainder of Medicare-approved amounts*	*100%* *$0* *80%*	*$0* *$0* *10%*	*$0* *$110 (Part B Deductible) ◆* *10% ◆*

PLAN L

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

** You will pay one-fourth the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $2,000 each calendar year.*

◆ The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coninsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

*** 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.*

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY**
*HOSPITALIZATION*** *Semiprivate room and board, general nursing and miscellaneous services and supplies:* *First 60 days* *61st thru 90th day* *91st day and after:* *While using 60 lifetime reserve days* *Once lifetime reserve days are used:* *Additional 365 days* *Beyond the additional 365 days*	***** ***** ***** *$0* *$0*	**** (75% of Part A Deductible)* ***** ***** *100% of Medicare Eligible Expenses* *$0*	**** (25% of Part A Deductible) ◆* *$0* *$0* *$0* *All costs*
*SKILLED NURSING FACILITY CARE*** *You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:* *First 20 days* *21st thru 100th day* *101st day and after*	*All approved amounts* ***** *$0*	*$0* ***** *$0*	*$0* **** ◆* *All costs*
BLOOD *First 3 pints* *Additional amounts*	*$0* *100%*	*75%* *$0*	*25% ◆* *$0*
HOSPICE CARE *Available as long as your doctor certifies you are terminally ill and you elect to receive these services*	*Generally, most Medicare eligible expenses for out-patient drugs and inpatient respite care*	*75% of coinsurance or copayments*	*25% of coinsurance or copayments ◆*

PLAN L

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

**** Once you have been billed $110 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.***

◆◆ This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $2,000 per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

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 $110 of Medicare-approved amounts**	*$0*	*$0*	*$110 (Part B Deductible) ◆*
Preventive Benefits for Medicare covered services	*Generally 75% or more of Medicare-approved amounts*	*Remainder of Medicare-approved amounts*	*All costs above Medicare-approved amounts*
Remainder of Medicare-approved amounts	*Generally 80%*	*Generally 15%*	*Generally 5% ◆*
Part B Excess Charges (Above Medicare-approved amounts) ◆◆	*$0*	*$0*	*All costs*
BLOOD			
First 3 pints	*$0*	*75%*	*25% ◆*
*Next $110 of Medicare-approved amounts**	*$0*	*$0*	*$110 (Part B Deductible) ◆*
Remainder of Medicare-approved amounts	*Generally 80%*	*Generally 15%*	*Generally 5% ◆*
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	*100%*	*$0*	*$0*

PARTS A & B

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

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 $110 of Medicare-approved amounts***	*$0*	*$0*	*$110 (Part B Deductible) ◆*
Remainder of Medicare-approved amounts	*80%*	*15%*	*5% ◆*

Sec. 28. NAC 687B.255 is hereby amended to read as follows:

687B.255 1. An application for a policy to supplement Medicare must include questions designed to elicit information about whether, as of the date of the application, the applicant

currently has another policy to supplement Medicare, ~~[certificate or other]~~ ***Medicare Advantage, Medicaid coverage, or another*** health insurance ***policy or certificate in force*** or whether the policy to supplement Medicare or the certificate is intended to replace any other policy or certificate ~~[providing accident and sickness benefits.]~~ ***presently in force.*** A supplementary application or other form containing such questions and statements may be used if it is signed by the applicant and the issuer or its agent.

2. An application must contain the following statements and questions:

(a) You do not need more than one policy to supplement Medicare.

(b) You may be eligible for benefits under Medicaid and may not need a policy to supplement Medicare.

(c) ~~[The]~~ ***If, after purchasing this policy, you become eligible for Medicaid, the*** benefits and premiums under your policy to supplement Medicare may, if requested, be suspended during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days after becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your ***suspended*** policy ***to supplement Medicare, or, if that is no longer available, a substantially equivalent policy,*** will be reinstituted if requested within 90 days after loss of eligibility. ***If the policy to supplement Medicare provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.***

(d) ***If you are eligible for, and have enrolled in a policy to supplement Medicare by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your policy to supplement Medicare can be suspended, if***

requested, while you are covered under the employer or union-based group health plan. If you suspend your policy to supplement Medicare under these circumstances, and later lose your employer or union-based group health plan, your suspended policy to supplement Medicare or, if that is no longer available, a substantially equivalent policy, will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the policy to supplement Medicare provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(e) Counseling services may be available in your state to provide advice concerning your purchase of a policy to supplement Medicare and concerning medical assistance available through the state Medicaid program, including benefits available to qualified Medicare beneficiaries, as that term is defined in 42 U.S.C. § 1396d(p)(1), and to specified low-income Medicare beneficiaries, as described in 42 U.S.C. § 1396a(a)(10)(E)(iii).

~~[(e) To the best of your knowledge, do you have another policy or certificate to supplement Medicare that is in force? If so, with which company?~~

~~(f) Do you have any other coverage of health insurance that provides benefits similar to this policy to supplement Medicare? If so, with which company? What kind of coverage?~~

~~(g) If the answer to paragraph (e) or (f) is yes, do you intend to replace these medical or health policies or coverages with this policy or certificate?~~

~~(h) Are you covered for medical assistance through the state Medicaid program:~~

~~(1) As a specified low-income Medicare beneficiary?~~

~~(2) As a qualified Medicare beneficiary?~~

~~(3) For other Medicaid medical benefits?]~~

(f) If you lost or are losing your health insurance coverage and received a notice from your prior insurer saying that you were eligible for guaranteed issue of a policy to supplement Medicare, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our policies to supplement Medicare. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

(g) [Please mark Yes or No below with an "X"]

To the best of your knowledge,

(1) (a) Did you turn age 65 in the last 6 months?

Yes_____No_____

(b) Did you enroll in Medicare Part B in the last 6 months?

Yes_____No_____

(c) If yes, what is the effective date?_____

(2) Are you covered for medical assistance through the state Medicaid program?

[NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.]

Yes_____No_____

If yes,

(a) Will Medicaid pay your premiums for this Policy to supplement Medicare?

Yes_____No_____

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

Yes_____No_____

(3) (a) If you had coverage from any Medicare plan other than the original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

Start___/___/___End___/___/___

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new policy to supplement Medicare?

Yes_____No_____

(c) Was this your first time in this type of Medicare plan?

Yes_____No_____

(d) Did you drop a policy to supplement Medicare to enroll in the Medicare plan?

Yes_____No_____

(4) (a) Do you have another policy to supplement Medicare in force?

Yes_____No_____

(b) If so, with what company, and what plan do you have [optional for Direct Mailers]?

_____

(c) If so, do you intend to replace your current policy to supplement Medicare with this policy?

Yes_____No_____

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan)

Yes_____No_____

(a) If so, with what company and what kind of policy?

_____

_____

_____

_____

(b) What are your dates of coverage under the policy?

Start___/___/___End___/___/___

(If you are still covered under the other policy, leave "END" blank.)

3. An issuer shall provide to the applicant a list of any other policies of health insurance he has sold to the applicant. The list must include policies sold to the applicant which are in force at the time of the application and policies sold to the applicant in the previous 5 years which are no longer in force.

4. If the issuer is a direct response issuer, a copy of the application or supplemental form, signed by the applicant and acknowledged by the issuer, must be returned to the applicant by the issuer upon delivery of the policy to supplement Medicare.

5. Upon determining that the sale will involve the replacement of coverage to supplement Medicare, the issuer or its agent shall, before issuing or delivering the policy to supplement Medicare or the certificate, furnish the applicant with a notice regarding the replacement of coverage to supplement Medicare. One copy of the notice, signed by the applicant and the agent,

must be provided to the applicant and another copy, signed by the applicant, must be retained by the issuer.

6. A direct response issuer shall deliver the notice required by subsection 5 to the applicant at the time of the issuance of the policy to supplement Medicare.

7. The notice required by subsection 5:

(a) Must be in a form prescribed by the Division;

(b) Must be in not less than ~~[10-point]~~ ***12-point*** type; and

(c) Except as otherwise provided in subsection 8, must be in substantially the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT

OF INSURANCE TO SUPPLEMENT MEDICARE

OR MEDICARE ADVANTAGE

(Insurance company's name and address)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to (your application) (information you have furnished), you intend to terminate existing insurance to supplement Medicare ***or Medicare Advantage*** and replace it with a policy to be issued by (company name) Insurance Company. Your new policy will provide 30 days within which you may decide, without cost, whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all coverage for accidents and sickness you now have. If, after due consideration, you find that the purchase of this coverage to supplement Medicare is a wise decision, you should terminate your present policy to supplement Medicare ~~[.]~~ ***or Medicare Advantage.*** You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICATION BY ISSUER, AGENT (BROKER OR OTHER REPRESENTATIVE):

I have reviewed the coverage provided by your current policies of medical or health insurance. This policy to supplement Medicare will not duplicate your existing policy to supplement Medicare ***or, if applicable, Medicare Advantage*** because you intend to terminate your existing policy to supplement Medicare ~~[.]~~ ***or leave your Medicare Advantage plan.*** The replacement policy is being purchased for the following reason(s) (check one):

_____ Additional benefits.

_____ No change in benefits, but lower premiums.

_____ Fewer benefits and lower premiums.

_____ ***My plan has outpatient prescription drug coverage and I am enrolling in Medicare Part D.***

_____ ***Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. [optional only for Direct Mailers]***

_____

_____

_____

_____ Other (please specify).

Note: If the issuer of the policy to supplement Medicare being applied for does not, or is otherwise prohibited from, imposing pre-existing condition limitations, please skip to the next statement below. Any health condition which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in the denial of a claim for benefits or a delay in the payment of a claim under the new policy, whereas a similar claim might be payable under your present policy.

State law provides that your replacement policy or certificate may not contain any new preexisting condition, waiting period, elimination period or probationary period. The issuer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

If you still wish to terminate your present policy and replace it with new coverage, be certain to answer truthfully and completely all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. (If the policy or certificate is guaranteed issue, this paragraph need not appear.)

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

.....

(Signature of Agent, Broker or Other Representative)*

.....

[Typed Name and Address of Issuer, Agent or Broker]

.....

(Applicant's Signature)

.....

(Date)

*Signature not required for direct response sales.

8. The provisions of the replacement notice applicable to preexisting conditions may be deleted by an issuer if the replacement does not involve the application of a new limitation on a preexisting condition.

Sec. 29. NAC 687B.260 is hereby amended to read as follows:

687B.260 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. 30. NAC 687B.263 is hereby amended to read as follows:

687B.263 1. If a group policy to supplement Medicare or a certificate is terminated by the group policyholder or certificate holder and is not replaced as provided in subsection 3, the issuer shall offer each certificate holder an individual policy to supplement Medicare or a certificate. The issuer shall offer the certificate holder an individual policy that provides for the continuation of the benefits contained in the group policy.

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

(a) Offer the certificate holder an individual policy to supplement Medicare pursuant to subsection 1; or

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

3. If a group policy to supplement Medicare or a certificate is replaced by another group policy to supplement Medicare or certificate which is purchased by the same person, the issuer of the replacement policy or certificate shall offer coverage to all persons who are covered under the policy or certificate that is being replaced on the date it is terminated. The replacement policy or certificate may not provide for the exclusion of coverage for preexisting conditions that were covered under the policy or certificate that is being replaced.

4. If a policy to supplement Medicare eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173, 117 Stat. 2066, December 8, 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this section.

Sec. 31. NAC 687B.265 is hereby amended to read as follows:

687B.265 1. As soon as practicable, but not later than 30 days before the annual effective date of any changes in Medicare benefits, an issuer shall notify each policyholder and certificate holder of any modifications it has made to the policy to supplement Medicare or the certificate. The notice must:

(a) Include a description of any revisions to the Medicare program and a description of each modification made to the coverage provided under the policy or certificate.

(b) Inform each policyholder or certificate holder of the date on which any adjustment of premiums is to be made because of changes in Medicare.

(c) Be in outline form and in clear and simple terms so as to facilitate comprehension.

(d) Be in a format which is acceptable to the Commissioner.

2. The notice must not contain or be accompanied by any solicitation.

3. Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173, 117 Stat. 2066, December 8, 2003.

Sec. 32. NAC 687B.282 is hereby amended to read as follows:

687B.282 1. If an agent recommends the purchase or replacement of any policy to supplement Medicare or certificate, the agent shall make reasonable efforts to determine the appropriateness of the recommended purchase or replacement.

2. Any sale of a policy to supplement Medicare or a certificate that provides a person with more than one policy to supplement Medicare or certificate is prohibited.

3. An issuer shall not issue a policy to supplement Medicare or certificate to a person enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the person's Part C coverage.

Sec. 33. NAC 687B.290 is hereby amended to read as follows:

687B.290 1. An issuer who delivers or issues for delivery in this State a policy to supplement Medicare or a certificate on or after July 30, 1992, shall make available to each prospective insured a policy or certificate that provides only the following benefits:

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

(b) Coverage of Medicare Part A eligible expenses incurred for hospitalization to the extent they are not covered by Medicare for each Medicare lifetime inpatient reserve day used.

(c) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of ***100 percent of*** the Medicare Part A eligible expenses for hospitalization paid at the ~~[Diagnosis Related Group (DRG), day outlier per diem]~~ ***applicable prospective payment system (PPS) rate,*** or other appropriate ***Medicare*** standard of payment, subject to a lifetime maximum benefit of an additional 365 days.

(d) ~~[Coverage]~~ ***Plans A-J, inclusive, provide coverage*** under Medicare Part A and B for the reasonable cost of the first 3 pints of blood, or an equivalent quantity of packed red blood cells, as defined by federal regulations, unless replaced in accordance with federal regulations. ***Plans K and L provide for 50 percent and 75 percent, respectively, of the reasonable cost for the first 3 pints of blood.***

(e) Coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of confinement in a hospital, subject to the Medicare Part B deductible.

2. In addition to the benefits required by subsection 1, an issuer may make available to prospective insureds any other standardized benefit plans to supplement Medicare as set forth in NAC 687B.295 to 687B.319, inclusive ~~[.]~~ ***, and sections 9 and 10 of this regulation.***

Sec. 34. NAC 687B.308 is hereby amended to read as follows:

687B.308 A benefit plan to supplement Medicare which is designated as Standardized Benefit Plan E must provide the following benefits:

1. The benefits required by NAC 687B.290.

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

3. 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.

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

5. 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, and to the extent not covered by Medicare:

(a) An annual clinical medical history and physical examination that may include the tests and services set forth in paragraph (b) of this subsection and educational services that address measures to be taken for preventative health care.

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

~~(1) A digital rectal examination.~~

~~(2) A dipstick urinalysis for hematuria, bacteriuria and proteinuria.~~

~~(3) A pure tone hearing test using air only that is administered or ordered by a physician.~~

~~(4) A serum cholesterol screening every 5 years.~~

~~(5) A thyroid function test.~~

~~(6) A screening for diabetes.~~

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

~~(d) Any other tests or preventative measures deemed appropriate by the attending physician.]~~ ***Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.***

Sec. 35. NAC 687B.315 is hereby amended to read as follows:

687B.315 A benefit plan to supplement Medicare which is designated as Standardized Benefit Plan H must provide the following benefits:

1. The benefits required by NAC 687B.290.

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

3. 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.

4. ~~[As]~~ ***For plans sold or issued before January 1, 2006, as*** a basic benefit, coverage ***is provided*** 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 $1,250 in benefits received by the insured per calendar year, and to the extent not covered by Medicare. ***This subsection only applies to those persons currently covered by Plan H and who do not apply for Medicare Part D.***

5. Coverage of Medicare eligible expenses for 80 percent of the billed charges for medically necessary emergency care received in a foreign country to the extent not covered by Medicare, if

such care would have been covered by Medicare if provided in the United States and the care began during the first 60 consecutive days of the trip outside the United States. The benefit is subject to the payment of a deductible of $250 per calendar year and a lifetime maximum benefit of $50,000. As used in this subsection, “emergency care” means medical care needed immediately because of a sudden and unexpected injury or illness.

Sec. 36. NAC 687B.317 is hereby amended to read as follows:

687B.317 A benefit plan to supplement Medicare which is designated as Standardized Benefit Plan I must provide the following benefits:

1. The benefits required by NAC 687B.290.

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

3. 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.

4. 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.

5. ~~[As]~~ ***For plans sold or issued before January 1, 2006, as*** a basic benefit, coverage ***is provided*** 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 $1,250 in benefits received by the insured per calendar year, to the extent not covered by Medicare. ***This subsection only***

applies to those persons currently covered by Plan I and who do not apply for Medicare Part D.

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

7. 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.

Sec. 37. 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]~~ ***For plans sold or issued before January 1, 2006, as*** an extended benefit, coverage ***is provided*** 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. ***This paragraph only applies to those persons currently covered by Plan J and who do not apply for Medicare Part D.***

(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 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.]~~ ***Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically 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. 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.

Sec. 38. NAC 687B.330 is hereby amended to read as follows:

687B.330 ***1.*** An issuer may, with the prior approval of the Commissioner, offer a policy to supplement Medicare or a certificate with new or innovative benefits in addition to the benefits required by NAC 687B.290 to 687B.319, inclusive ~~[.]~~ ***, and sections 9 and 10 of this regulation.*** The new or innovative benefits may include benefits that are:

~~[1.]~~ ***(a)*** Appropriate to supplement Medicare;

~~[2.]~~ ***(b)*** Not otherwise available;

~~[3.]~~ ***(c)*** Cost-effective; and

~~[4.]~~ ***(d)*** Offered in a manner that is consistent with the goal of simplifying policies to supplement Medicare.

2. After December 31, 2005, an innovative benefit must not include an outpatient prescription drug benefit.

Sec. 39. NAC 687B.368 is hereby amended to read as follows:

687B.368 1. A Medicare select issuer shall disclose in writing the provisions, restrictions and limitations of the Medicare select policy or certificate to each applicant. The disclosure must include:

(a) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare select policy or certificate with:

(1) Other policies or certificates to supplement Medicare offered by the Medicare select issuer; and

(2) Other Medicare select policies.

(b) A description of the primary care physicians, specialty physicians, hospitals and other network providers, including their addresses, phone numbers and hours of operation.

(c) A description of the provisions for a restricted network, including those provisions addressing payments for coinsurance and deductibles when providers other than network providers are utilized. ***Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in Plans K and L.***

(d) A description of coverage for emergency and urgently needed care and coverage for care provided outside the service area.

(e) A description of any limitations on referrals by network providers to persons other than network providers.

(f) A description of the policyholder's or certificate holder's rights to purchase other policies or certificates to supplement Medicare that the Medicare select issuer offers.

(g) A description of the program for quality assurance and the procedure for addressing grievances that the Medicare select issuer utilizes.

2. Before the sale of a Medicare select policy or certificate, a Medicare select issuer must obtain from the applicant a signed and dated form stating that the applicant has received the written disclosure required by subsection 1 and that the applicant understands the restrictions of the Medicare select policy or certificate.

Sec. 40. NAC 687B.372 is hereby amended to read as follows:

687B.372 1. A Medicare select issuer shall offer to each applicant for a Medicare select policy or certificate, at the time of initial purchase, the opportunity to purchase any policies or certificates to supplement Medicare that the Medicare select issuer offers.

2. Upon request by a policyholder or certificate holder, a Medicare select issuer shall make available the opportunity to purchase a different policy or certificate to supplement Medicare offered by the Medicare select issuer which has comparable or lesser benefits and which does not contain a provision for a restricted network. The Medicare select issuer shall make such policies or certificates available without requiring evidence of insurability if the person has been a policyholder or certificate holder for 6 months or more.

3. For the purposes of this section, a policy or certificate to supplement Medicare will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare select policy or certificate being replaced. For the purposes of this subsection, a significant benefit means coverage for the Medicare Part A deductible, ~~[coverage for prescription drugs,]~~ coverage for at-home recovery services or coverage for Medicare Part B excess charges.

Sec. 41. NAC 687B.374 is hereby amended to read as follows:

687B.374 1. Medicare select policies and certificates must provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare

select policies and certificates issued pursuant to NAC 687B.340 to 687B.376, inclusive, must be discontinued because the Medicare select program has not been reauthorized by Congress or because the statutory authority for the program has been substantially amended.

2. If the Secretary of Health and Human Services makes such a determination, each Medicare select issuer shall make available to each policyholder and certificate holder the opportunity to purchase any policy to supplement Medicare offered by the Medicare select issuer which has comparable or lesser benefits and which does not contain a provision for a restricted network. The Medicare select issuer shall make such policies and certificates available without requiring evidence of insurability.

3. For the purposes of this section, a policy to supplement Medicare will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare select policy or certificate being replaced. For the purpose of this subsection, a significant benefit means coverage for the Medicare Part A deductible, ~~[coverage for prescription drugs,]~~ coverage for at-home recovery services or coverage for Part B excess charges.

Sec. 42. NAC 687B.700 is hereby amended to read as follows:

687B.700 1. An insurer that delivers or issues for delivery in this State a policy of health insurance which provides limited reimbursement for expenses incurred and limited reimbursement for expenses incurred on a fixed-indemnity basis and which provides benefits that are provided under Medicare shall provide notice to the insured that the policy contains certain benefits which are also provided under Medicare.

2. The notice must be:

(a) Printed on or attached to the first page of the application for the policy; and

(b) In not less than 12-point type and contain the following language in substantially the following form:

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement Insurance.

This insurance duplicates Medicare benefits when:

- Any expenses or services covered by the policy are also covered by Medicare.
- It pays the fixed dollar amount stated in the policy and Medicare covers the same event.

Medicare generally pays for most or all of these expenses. Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice care

- ***Outpatient prescription drugs if you are enrolled in Medicare Part D***
- Other approved items and services

Before You Buy This Insurance:

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement Insurance, review the *Guide to Health Insurance for People with Medicare,* which is available from the insurance company.
- For help in understanding your health insurance, contact the Commissioner of Insurance or the ~~[Nevada Medicare Information, Counseling and]~~ ***State Health Insurance*** Assistance Program ~~[.]~~ ***(SHIP).***

Sec. 43. NAC 687B.720 is hereby amended to read as follows:

687B.720 1. An insurer that delivers or issues for delivery in this State a policy of health insurance which provides reimbursement for expenses incurred for certain specified diseases and other specified medical conditions and which provides benefits that are provided under Medicare shall provide notice to the insured that the policy contains certain benefits which are also provided under Medicare.

2. The notice must be:

(a) Printed on or attached to the first page of the application for the policy; and

(b) In not less than 12-point type and contain the following language in substantially the following form:

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement Insurance.

This insurance duplicates Medicare benefits when it pays:

- Hospital or medical expenses up to the maximum stated in the policy.

Medicare generally pays for most or all of these expenses. Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- ***Outpatient prescription drugs if you are enrolled in Medicare Part D***
- Hospice
- Other approved items and services

Before You Buy This Insurance:

- Check the coverage in all health insurance policies you already have.

- For more information about Medicare and Medicare Supplement Insurance, review the *Guide to Health Insurance for People with Medicare*, which is available from the insurance company.
- For help in understanding your health insurance, contact the Commissioner of Insurance or the ~~[Nevada Medicare Information, Counseling and]~~ ***State Health Insurance*** Assistance Program ~~[.]~~ ***(SHIP).***

Sec. 44. NAC 687B.725 is hereby amended to read as follows:

687B.725 1. An insurer that delivers or issues for delivery in this State a policy of health insurance which provides limited reimbursement for certain specified expenses incurred and which provides benefits that are provided under Medicare shall provide notice to the insured that the policy contains certain benefits which are also provided under Medicare.

2. The notice must be:

(a) Printed on or attached to the first page of the application for the policy; and

(b) In not less than 12-point type and contain the following language in substantially the following form:

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement Insurance.

This insurance duplicates Medicare benefits when:

- Any of the services covered by the policy are also covered by Medicare.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- ***Outpatient prescription drugs if you are enrolled in Medicare Part D***
- Other approved items and services

Before You Buy This Insurance:

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement Insurance, review the *Guide to Health Insurance for People with Medicare*, which is available from the insurance company.
- For help in understanding your health insurance, contact the Commissioner of Insurance or the ~~[Nevada Medicare Information, Counseling and]~~ ***State Health Insurance*** Assistance Program ~~[.]~~ ***(SHIP).***

Sec. 45. NAC 687B.730 is hereby amended to read as follows:

687B.730 1. An insurer that delivers or issues for delivery in this State a policy of health insurance, other than a policy of insurance described in NAC 687B.700 to 687B.725, inclusive, which provides benefits that are provided under Medicare shall provide notice to the insured that the policy contains certain benefits which are also provided under Medicare.

2. The notice must be:

(a) Printed on or attached to the first page of the application for the policy; and

(b) In not less than 12-point type and contain the following language in substantially the following form:

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement Insurance.

This insurance duplicates Medicare benefits when it pays:

- The benefits stated in the policy and coverage for the same event is provided by Medicare.

Medicare generally pays for most or all of these expenses. Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services

- Hospice care
- ***Outpatient prescription drugs if you are enrolled in Medicare Part D***
- Other approved items and services

Before You Buy This Insurance:

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement Insurance, review the *Guide to Health Insurance for People with Medicare*, which is available from the insurance company.
- For help in understanding your health insurance, contact the Commissioner of Insurance or the ~~[Nevada Medicare Information, Counseling and]~~ ***State Health Insurance*** Assistance Program ~~[.]~~ ***(SHIP).***

Sec. 46. This regulation becomes effective on January 1, 2006.