APPROVED REGULATION OF

THE COMMISSIONER OF INSURANCE

LCB File No. R041-17

Effective June 26, 2019

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

AUTHORITY: §§1-16, NRS 679B.130 and 687B.430.

A REGULATION relating to insurance; providing for 2020 standardized benefit plans to supplement Medicare; revising requirements applicable to 2010 standardized benefit plans to supplement Medicare; revising the forms for outlines of coverage provided to applicants for standardized benefit plans to supplement Medicare; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law authorizes the Commissioner of Insurance to adopt reasonable regulations for the administration of the Nevada Insurance Code and reasonable regulations as required to ensure compliance with federal law relating to insurance. (NRS 679B.130) Existing law also authorizes the Commissioner to adopt regulations relating to the form, content and sale of policies of insurance which provide for the payment of expenses which are not covered by Medicare. (NRS 687B.430)

A policy of insurance which provides for the payment of expenses which are not covered by Medicare is commonly referred to as a Medicare supplement policy or a Medigap policy, among other common names, and is referred to in existing regulations as a policy to supplement Medicare or a standardized benefit plan to supplement Medicare. (NAC 687B.204, 687B.2045) Existing regulations govern the form, content and sale of such policies to supplement Medicare. (NAC 687B.200-687B.330) Specifically, existing regulations govern 1990 standardized benefit plans to supplement Medicare, which are policies to supplement Medicare that were issued on or after January 1, 1992, and with an effective date for coverage before June 1, 2010. (NAC 687B.2002) Existing regulations also govern 2010 standardized benefit plans to supplement Medicare, which are policies to supplement Medicare that were issued with an effective date for coverage on or after June 1, 2010. (NAC 687B.2003)

Congress revised federal law relating to policies to supplement Medicare when it enacted the Medicare Access and CHIP Reauthorization Act of 2015, commonly known as MACRA. (Public Law 114-10) Among other changes, MACRA revised the federal requirements applicable to policies to supplement Medicare issued to persons newly eligible for Medicare on or after January 1, 2020. This regulation revises existing Nevada regulations governing policies to supplement Medicare to make the Nevada regulations consistent with federal requirements as revised by MACRA. Specifically, this regulation provides for 2020 standardized benefit plans to

supplement Medicare for persons newly eligible for Medicare on or after January 1, 2020, and revises requirements relating to 2010 standardized benefit plans to supplement Medicare as needed to account for the 2020 standardized benefit plans to supplement Medicare. The primary substantive difference between the 2010 standardized benefit plans to supplement Medicare, which may continue to be issued after January 1, 2020, only to persons who were eligible for Medicare before January 1, 2020, and the 2020 standardized benefit plans to supplement Medicare, which are the only policies to supplement Medicare which may be issued to persons newly eligible for Medicare on or after January 1, 2020, is that the 2020 standardized benefit plans to supplement Medicare are prohibited from providing any coverage for any portion of Medicare Part B deductibles.

Sections 2 and 3 of this regulation set forth definitions of "2020 standardized benefit plan to supplement Medicare" and "newly eligible on or after January 1, 2020," as needed to set forth separate requirements applicable to the 2020 standardized benefit plans to supplement Medicare issued to persons newly eligible on or after January 1, 2020.

Section 4 of this regulation prohibits the issuance or provision of specified policies, plans and benefits to persons newly eligible on or after January 1, 2020, while expressly retaining requirements applicable to 2010 standardized benefit plans to supplement Medicare. **Section 4** also provides for the issuance of the new High Deductible Benefit Plan G to persons otherwise eligible to be issued 2010 standardized benefit plans to supplement Medicare.

Section 5 of this regulation sets forth the requirements applicable to 2020 standardized benefit plans to supplement Medicare, including the creation of the new High Deductible Benefit Plan G. **Sections 6-12, 14 and 15** of this regulation make conforming changes consistent with the requirements set forth in **section 5**.

Section 13 of this regulation revises the forms for the outlines of coverage which must be provided to applicants for standardized benefit plans to supplement Medicare.

Section 1. Chapter 687B of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 6, inclusive, of this regulation.

Sec. 2. ***"2020 standardized benefit plan to supplement Medicare" means a policy to supplement Medicare issued to an individual who is newly eligible on or after January 1, 2020.***

Sec. 3. ***"Newly eligible on or after January 1, 2020" means an individual who:***

1. Becomes 65 years of age on or after January 1, 2020; or

2. First becomes eligible for Medicare benefits because of age, disability or end-stage renal disease on or after January 1, 2020.

Sec. 4. *1. An issuer shall not advertise, solicit, deliver or issue for delivery in this State to an individual who is newly eligible on or after January 1, 2020, a:*

(a) Standardized Benefit Plan C;

(b) Standardized Benefit Plan F; or

(c) High Deductible Benefit Plan F.

2. A policy to supplement Medicare, or a certificate, which is advertised, solicited, delivered or issued for delivery in this State to an individual who is newly eligible on or after January 1, 2020, must not provide coverage for any portion of the Medicare Part B deductible.

3. On or after January 1, 2020:

(a) An issuer shall not advertise, solicit, deliver or issue for delivery in this State a policy to supplement Medicare, or a certificate, unless the policy or certificate:

(1) Complies with the standards applicable to a 2020 standardized benefit plan to supplement Medicare, including, without limitation, the standards set forth in NAC 687B.250 and section 6 of this regulation; or

(2) Is advertised, solicited, delivered or issued for delivery to an individual who is eligible for Medicare before January 1, 2020.

(b) The benefit standards applicable to a policy to supplement Medicare, or a certificate, remain subject to all requirements applicable to a 2010 standardized benefit plan to supplement Medicare, including, without limitation, NAC 687B.2003, 687B.2273, 687B.250, 687B.322 and 687B.323, if the policy or certificate:

(1) Was issued with an effective date for coverage on or after June 1, 2010; and

(2) Is issued to an individual who is eligible for Medicare before January 1, 2020.

(c) In addition to the 2010 standardized benefit plans to supplement Medicare described in subsection 7 of NAC 687B.323, an issuer may offer for sale the standardized benefit plan described in paragraph (c) of subsection 3 of section 6 of this regulation, referred to as a High Deductible Benefit Plan G, to an individual who is eligible for Medicare before January 1, 2020.

Sec. 5. *1. The standards set forth in this section are applicable to every 2020 standardized benefit plan to supplement Medicare.*

2. Except as otherwise provided in subsection 3, a 2020 standardized benefit plan to supplement Medicare must comply with the requirements applicable to a 2010 standardized benefit plan to supplement Medicare, as set forth in NAC 687B.200 to 687B.330, inclusive, and sections 2 to 6 inclusive, of this regulation, including, without limitation, NAC 687B.2057, 687B.206, 687B.2062, 687B.250, 687B.322 and 687B.323.

3. For the purposes of a 2020 standardized benefit plan to supplement Medicare:

(a) In NAC 687B.2057, 687B.206 and 687B.2062:

(1) The references to Standardized Benefit Plan C, Plan C or C policy shall be deemed to be references to Standardized Benefit Plan D, Plan D or D policy, as applicable;

(2) The references to Standardized Benefit Plan F, Plan F or F policy shall be deemed to be references to Standardized Benefit Plan G, Plan G or G policy, as applicable; and

(3) The references to Standardized Benefit Plan F with a high deductible, Plan F with a high deductible or F with a high deductible policy shall be deemed to be references to Standardized Benefit Plan G with a high deductible, Plan G with a high deductible or G with a high deductible policy, as applicable.

(b) In subsection 3 of NAC 687B.323:

(1) The reference to a Standardized Benefit Plan C as described in paragraph (c) of subsection 7 of NAC 687B.323 shall be deemed to be a reference to a Standardized Benefit Plan D as described in paragraph (d) of subsection 7 of NAC 687B.323; and

(2) The reference to a Standardized Benefit Plan F as described in paragraph (e) of subsection 7 of NAC 687B.323 shall be deemed to be a reference to a Standardized Benefit Plan G as described in paragraph (g) of subsection 7 of NAC 687B.323.

(c) In paragraph (f) of subsection 7 of NAC 687B.323, the reference to a Standardized Benefit Plan F shall be deemed to be a reference to a Standardized Benefit Plan G and the reference to a High Deductible Benefit Plan F shall be deemed to be a reference to a High Deductible Benefit Plan G. Such a High Deductible Benefit Plan G must provide:

(1) The benefits specified in paragraph (f) of subsection 7 of NAC 687B.323 except that it must not provide coverage for any portion of the Medicare Part B deductible; and

(2) That any amount paid by the beneficiary for the Medicare Part B deductible is an out-of-pocket expense for the purpose of the annual deductible.

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

687B.200 As used in NAC 687B.200 to 687B.330, inclusive, ***and sections 2 to 6, inclusive, of this regulation,*** unless the context otherwise requires, the words and terms defined in NAC 687B.2002 to 687B.2045, inclusive, ***and sections 2, 3 and 4 of this regulation*** have the meanings ascribed to them in those sections.

Sec. 7. NAC 687B.2003 is hereby amended to read as follows:

687B.2003 "2010 standardized benefit plan to supplement Medicare" or "2010 standardized benefit plan" means a policy to supplement Medicare issued with an effective date for coverage

on or after June 1, 2010 ~~[.]~~ ***, and which is not issued to an individual who is newly eligible on or after January 1, 2020.***

Sec. 8. NAC 687B.2045 is hereby amended to read as follows:

687B.2045 "Standardized benefit plan" means ***, as applicable,*** a benefit plan to supplement Medicare that is designated as Standardized Benefit Plan A through N, inclusive, or High Deductible Benefit Plan F ***, G*** or J, as set forth in NAC 687B.300 to 687B.323, inclusive ~~[.]~~ ***, and section 6 of this regulation.***

Sec. 9. NAC 687B.2057 is hereby amended to read as follows:

687B.2057 ~~[The]~~ ***Except as otherwise provided in section 6 of this regulation, the*** policy to supplement Medicare to which eligible persons are entitled:

1. Under paragraphs (a), (b), (c) and (d) of subsection 3 of NAC 687B.2053 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 NAC 687B.2053 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 NAC 687B.2053 shall include any policy to supplement Medicare offered by any issuer; or

5. Under paragraph (g) of subsection 3 of NAC 687B.2053 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. 10. 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 the person provides evidence that he or she 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 Advantage plan offered by a Medicare Advantage organization pursuant to Medicare Part C, if the person was allowed to disenroll from the Medicare 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 Advantage plan because:

(I) His or her residence changed;

(II) The Medicare 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 Advantage organization offering the Medicare Advantage plan substantially violated a material provision of the contract of the Medicare 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 Advantage plan or failing to provide such care in accordance with applicable quality standards; or

(II) The Medicare Advantage organization, agent or other person acting on behalf of the Medicare Advantage organization made a material misrepresentation of the provisions of the Medicare 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 or she were enrolled in a Medicare 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 or she was notified by the Medicare Advantage organization of the impending termination or discontinuance of the Medicare Advantage plan offered by the Medicare 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 Advantage plan involved.

3. ~~[A]~~ ***Except as otherwise provided in section 6 of this regulation, 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 (including F with a high deductible), K or L.

4. ~~[After]~~ ***Except as otherwise provided in section 6 of this regulation, 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. 11. 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 the person provides evidence that he or she:

(a) Disenrolled from such a policy or certificate;

(b) Subsequently enrolled for the first time in:

(1) A Medicare Advantage plan offered by a Medicare 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 the person's enrollment as authorized pursuant to section 1851(e) of the Social Security Act, 42 U.S.C. § 1395w-21(e).

2. ~~[A]~~ ***Except as otherwise provided in section 6 of this regulation, 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 or her 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, the person 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 (including F with a high deductible), K or L.

Sec. 12. NAC 687B.2273 is hereby amended to read as follows:

687B.2273 1. ~~[On]~~ ***Except as otherwise provided in section 6 of this regulation, on*** or after June 1, 2010, no policy or certificate may be advertised, solicited, delivered or issued for delivery in this State as a policy to supplement Medicare or a certificate unless it complies with the standards provided for in NAC 687B.322 and 687B.323.

2. No issuer may offer any 1990 standardized benefit plan to supplement Medicare for sale on or after June 1, 2010.

3. Benefit standards applicable to a policy to supplement Medicare or a certificate issued with an effective date for coverage before June 1, 2010, remain subject to the requirements of NAC 687B.225, 687B.226, 687B.227, 687B.290 and 687B.295.

Sec. 13. 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 or she 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. All plans 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 Assistance Program (SHIP) of the Aging and Disability Services Division of the Department of Health and Human Services for help in understanding his or her health insurance.

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

Benefit Chart of Medicare Supplement Plans Sold with an Effective Date for Coverage On or After June 1, 2010 ***, and Before January 1, 2020***

This chart shows the benefits included in each of the Standard Medicare Supplement Plans. Every company must make Plan "A" available. Some plans may not be available in your state.

Basic Benefits:
Hospitalization - Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses - Part B coinsurance (generally 20 percent of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
Blood - First three pints of blood each year.
Hospice - Part A coinsurance.

A	B	C	D	F	F *	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance		Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to *** copayment for office visit, and up to *** copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				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
							Out-of-pocket limit**; paid at 100% after limit reached	Out-of-pocket limit**; paid at 100% after limit reached		

* Plan F also has an option called a High Deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses exceed the deductible. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These

expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

** Out-of-pocket limit will increase each year for inflation.

*** The amount that Medicare does not pay is subject to change. For the current amount that Medicare does not pay, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an insurer to an applicant pursuant to NAC 687B.240.

Benefit Chart of Medicare Supplement Plans Sold with an Effective Date for Coverage On or After January 1, 2020

This chart shows the benefits included in each of the Standard Medicare Supplement Plans. Some Plans may not be available. Only applicants first eligible for Medicare before 2020 may purchase Plans C, F and High Deductible F.

Note: A ✔ means 100% of the benefit is paid.

Benefits	*Plans Available to All Applicants*								*Medicare First Eligible Before 2020 Only*	
	A	*B*	*D*	*G[1]*	*K*	*L*	*M*	*N*	*C*	*F [1]*
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Medicare Part B coinsurance or Copayment	✔	✔	✔	✔	*50%*	*75%*	✔	✔ *copays apply[3]*	✔	✔
Blood (first three pints)	✔	✔	✔	✔	*50%*	*75%*	✔	✔	✔	✔
Part A hospice care coinsurance or copayment	✔	✔	✔	✔	*50%*	*75%*	✔	✔	✔	✔
Skilled nursing facility coinsurance			✔	✔	*50%*	*75%*	✔	✔	✔	✔
Medicare Part A Deductible		✔	✔	✔	*50%*	*75%*	*50%*	✔	✔	✔
Medicare Part B Deductible									✔	✔
Medicare Part B excess charges				✔						✔
Foreign travel emergency (up to plan limits)			✔	✔			✔	✔	✔	✔
Out-of-pocket limit [2]					*** [2]*	*** [2]*				

[1] Plans F and G also have a high deductible option which require first paying a plan deductible before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High Deductible Plan G does not cover the Medicare Part B Deductible. However, high deductible plans F and G count your payment of the Medicare Part B Deductible toward meeting the plan deductible.

[2] Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3] Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in an inpatient admission.

*** Out-of-pocket limit will increase each year for inflation.*

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.

READY 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 both 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.

** The amount that Medicare does not pay is subject to change. For the current amount that Medicare does not pay, 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.

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

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

PLAN A

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

* Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (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 portion of Medicare-approved amounts *	$0	$0	(Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD First 3 pints	$0	All costs	$0
Next portion of Medicare-approved amounts *	$0	$0	(Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN A

PARTS A & B

* Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (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 portion of Medicare-approved amounts *	100% $0	$0 $0	$0 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN B

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

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

** The amount that Medicare does not pay is subject to change. For the current amount that Medicare does not pay, 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.

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

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

PLAN B

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

* Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (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

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 portion of Medicare-approved amounts *	$0	$0	(Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next portion of Medicare-approved amounts*	$0	$0	(Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN B

PARTS A & B

* Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

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

PLAN C

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

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

** The amount that Medicare does not pay is subject to change. For the current amount that Medicare does not pay, 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.

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

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

PLAN C

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

* Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (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 portion of Medicare-approved amounts *	$0	(Part B Deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next portion of Medicare-approved amounts *	$0	(Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN C

PARTS A & B

* Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (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 portion of Medicare-approved amounts *	100% $0	$0 (Part B Deductible)	$0 $0
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN C

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

PLAN D

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

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

** The amount that Medicare does not pay is subject to change. For the current amount that Medicare does not pay, 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.

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

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

PLAN D

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

* Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (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 portion of Medicare-approved amounts * Remainder of Medicare-approved amounts	 $0 Generally 80%	 $0 Generally 20%	 (Part B Deductible) $0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD First 3 pints Next portion of Medicare-approved amounts * Remainder of Medicare-approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 (Part B Deductible) $0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN D

PARTS A & B

* Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (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 portion of Medicare-approved amounts * Remainder of Medicare-approved amounts	 100% $0 80%	 $0 $0 20%	 $0 (Part B Deductible) $0

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 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.~~

~~** The amount that Medicare does not pay is subject to change. For the current amount that Medicare does not pay, 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.~~

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

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

PLAN F

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

* Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (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 portion of Medicare-approved amounts *	$0	(Part B Deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next portion of Medicare-approved amounts *	$0	(Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN F

PARTS A & B

* Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

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

PLAN F

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

HIGH DEDUCTIBLE BENEFIT PLAN F

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

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

** The amount that Medicare does not pay is subject to change. For the current amount that Medicare does not pay, 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.

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

**** The High Deductible Benefit Plan F pays the same benefits as the Standardized Benefit Plan F after one has paid a calendar year 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. Benefits from the High Deductible Benefit Plan F will not begin until out-of-pocket expenses are equal to the calendar year deductible. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes, without limitation, the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

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	 All but ** All but ** a day All but ** a day $0 $0	 (Part A Deductible) ** a day ** a day 100% of Medicare Eligible Expenses $0	 $0 $0 $0 $0*** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	 All approved amounts All but ** a day $0	 $0 Up to ** a day $0	 $0 $0 All costs
BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

HIGH DEDUCTIBLE BENEFIT PLAN F

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

* Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year. The 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 pays the same benefits as the Standardized Benefit Plan F after one has paid a calendar year 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. Benefits from the High Deductible Benefit Plan F will not begin until out-of-pocket expenses are equal to the calendar year deductible. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes, without limitation, the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

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 portion of Medicare-approved amounts *	$0	(Part B Deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next portion of Medicare-approved amounts *	$0	(Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE BENEFIT PLAN F

MEDICARE (PARTS A & B)

* Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year. The 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 pays the same benefits as the Standardized Benefit Plan F after one has paid a calendar year 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. Benefits from the High Deductible Benefit Plan F will not begin until out-of-pocket expenses are equal to the calendar year deductible. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes, without limitation, the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

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	100%	$0	$0
Durable medical equipment:			
First portion of Medicare-approved amounts *	$0	(Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

HIGH DEDUCTIBLE BENEFIT PLAN F

OTHER BENEFITS - NOT COVERED BY MEDICARE

* The High Deductible Benefit Plan F pays the same benefits as the Standardized Benefit Plan F after one has paid a calendar year 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. Benefits from the High Deductible Benefit Plan F will not begin until out-of-pocket expenses are equal to the calendar year deductible. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes, without limitation, the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

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.

** The amount that Medicare does not pay is subject to change. For the current amount that Medicare does not pay, 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.

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

PLAN G

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

* Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (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 portion of Medicare-approved amounts * Remainder of Medicare-approved amounts	 $0 Generally 80%	 $0 Generally 20%	 (Part B Deductible) $0
Part B Excess Charges (Above Medicare-approved amounts)	$0	100%	$0
BLOOD First 3 pints Next portion of Medicare-approved amounts * Remainder of Medicare-approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 (Part B Deductible) $0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN G

PARTS A & B

* Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (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 portion of Medicare-approved amounts * Remainder of Medicare-approved amounts	 100% $0 80%	 $0 $0 20%	 $0 (Part B Deductible) $0

~~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 F or HIGH DEDUCTIBLE 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.***

***** The amount that Medicare does not pay is subject to change. For the current amount that Medicare does not pay, 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.***

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

******* The High Deductible Benefit Plan F pays the same benefits as the Standardized Benefit Plan F after you have paid a calendar year 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. Benefits from the High Deductible Benefit Plan F will not begin until out-of-pocket expenses are equal to the calendar year deductible. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes, without limitation, the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.***

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

SERVICES	*MEDICARE PAYS*	*AFTER YOU PAY THE DEDUCTIBLE, PLAN PAYS *****	*IN ADDITION TO THE DEDUCTIBLE, 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	***All approved amounts***	***$0***	***$0***
21st thru 100th day	***All but ** a day***	***Up to ** a day***	***$0***
101st day and after	***$0***	***$0***	***All costs***
BLOOD			
First 3 pints	***$0***	***3 pints***	***$0***
Additional amounts	***100%***	***$0***	***$0***
HOSPICE CARE ***You must meet Medicare's requirements, including a doctor's certification of terminal illness***	***All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care***	***Medicare copayment/ coinsurance***	***$0***

PLAN F or HIGH DEDUCTIBLE PLAN F

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

**** Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.***

******* The High Deductible Benefit Plan F pays the same benefits as the Standardized Benefit Plan F after you have paid a calendar year 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. Benefits from the High Deductible Benefit Plan F will not begin until out-of-pocket expenses are equal to the calendar year deductible. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes, without limitation, the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.***

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 portion of Medicare-approved amounts*	***$0***	***(Part B Deductible)***	***$0***
Remainder of Medicare-approved amounts	***Generally 80%***	***Generally 20%***	***$0***

SERVICES	*MEDICARE PAYS*	*AFTER YOU PAY THE DEDUCTIBLE, PLAN PAYS *****	*IN ADDITION TO THE DEDUCTIBLE, YOU PAY *****
Part B Excess Charges (Above Medicare-approved amounts)	*$0*	*100%*	*$0*
BLOOD			
First 3 pints	*$0*	*All costs*	*$0*
*Next portion of Medicare-approved amounts**	*$0*	*(Part B Deductible)*	*$0*
Remainder of Medicare-approved amounts	*80%*	*20%*	*$0*
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	*100%*	*$0*	*$0*

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

** Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.*

***** The High Deductible Benefit Plan F pays the same benefits as the Standardized Benefit Plan F after you have paid a calendar year 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. Benefits from the High Deductible Benefit Plan F will not begin until out-of-pocket expenses are equal to the calendar year deductible. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes, without limitation, the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.*

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	*100%*	*$0*	*$0*
Durable medical equipment			
*First portion of Medicare-approved amounts**	*$0*	*(Part B Deductible)*	*$0*
Remainder of Medicare-approved amounts	*80%*	*20%*	*$0*

PLAN F or HIGH DEDUCTIBLE PLAN F

OTHER BENEFITS - NOT COVERED BY MEDICARE

***** The High Deductible Benefit Plan F pays the same benefits as the Standardized Benefit Plan F after you have paid a calendar year 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. Benefits from the High Deductible Benefit Plan F will not begin until out-of-pocket expenses are equal to the calendar year deductible. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the*

policy. This includes, without limitation, the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

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

PLAN G or HIGH DEDUCTIBLE 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.*

*** The amount that Medicare does not pay is subject to change. For the current amount that Medicare does not pay, 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.*

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

***** The High Deductible Plan G pays the same benefits as the Standardized Benefit Plan G after you have paid a calendar year deductible. Benefits from the High Deductible Plan G will not begin until out-of-pocket expenses are equal to the calendar year deductible. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B Deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.*

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

PLAN G or HIGH DEDUCTIBLE PLAN G

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

SERVICES	*MEDICARE PAYS*	*AFTER YOU PAY THE DEDUCTIBLE, PLAN PAYS *****	*IN ADDITION TO THE DEDUCTIBLE, 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	***All approved amounts***	***$0***	***$0***
21st thru 100th day	***All but ** a day***	***Up to ** a day***	***$0***
101st day and after	***$0***	***$0***	***All costs***
BLOOD			
First 3 pints	***$0***	***3 pints***	***$0***
Additional amounts	***100%***	***$0***	***$0***
HOSPICE CARE ***You must meet Medicare's requirements, including a doctor's certification of terminal illness***	***All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care***	***Medicare copayment/coinsurance***	***$0***

PLAN G or HIGH DEDUCTIBLE PLAN G

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

****** Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.***

********* The High Deductible Benefit Plan G pays the same benefits as the Standardized Benefit Plan G after you have paid a calendar year deductible. The annual deductible for the High Deductible Benefit Plan G 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. Benefits from the High Deductible Benefit Plan G will not begin until out-of-pocket expenses are equal to the calendar year deductible. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B Deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.***

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 portion of Medicare-approved amounts*	***$0***	***$0***	***(Part B Deductible, unless Part B Deductible has been met)***

SERVICES	*MEDICARE PAYS*	*AFTER YOU PAY THE DEDUCTIBLE, PLAN PAYS *****	*IN ADDITION TO THE DEDUCTIBLE, YOU PAY *****
Remainder of Medicare-approved amounts	*Generally 80%*	*Generally 20%*	*$0*
Part B Excess Charges (Above Medicare-approved amounts)	*$0*	*100%*	*$0*
BLOOD			
First 3 pints	*$0*	*All costs*	*$0*
*Next portion of Medicare-approved amounts**	*$0*	*$0*	*(Part B Deductible, unless Part B Deductible has been met)*
Remainder of Medicare-approved amounts	*80%*	*20%*	*$0*
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	*100%*	*$0*	*$0*

PLAN G or HIGH DEDUCTIBLE PLAN G
PARTS A & B

** Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.*

***** The High Deductible Benefit Plan G pays the same benefits as the Standardized Benefit Plan G after you have paid a calendar year deductible. The annual deductible for the High Deductible Benefit Plan G 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. Benefits from the High Deductible Benefit Plan G will not begin until out-of-pocket expenses are equal to the calendar year deductible. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B Deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.*

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	*100%*	*$0*	*$0*
Durable medical equipment:			
*First portion of Medicare-approved amounts**	*$0*	*$0*	*(Part B Deductible, unless Part B Deductible has been met)*
Remainder of Medicare-approved amounts	*80%*	*20%*	*$0*

PLAN G or HIGH DEDUCTIBLE PLAN G

OTHER BENEFITS - NOT COVERED BY MEDICARE

***** The High Deductible Benefit Plan G pays the same benefits as the Standardized Benefit Plan G after you have paid a calendar year deductible. The annual deductible for the High Deductible Benefit Plan G 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. Benefits from*

the High Deductible Benefit Plan G will not begin until out-of-pocket expenses are equal to the calendar year deductible. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B Deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

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

PLAN 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 each calendar year.

** 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.

*** The amount that Medicare does not pay is subject to change. For the current amount that Medicare does not pay, 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.

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

◆ 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 coinsurance 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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but ***	(50% of Part A Deductible)	(50% of Part A Deductible)◆
61st thru 90th day	All but *** a day	*** a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but *** a day	*** a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0****
Beyond the additional 365 days	$0	$0	All costs

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 All but *** a day $0	 $0 Up to 50% of *** a day (50% of Part A Coinsurance) $0	 $0 Up to 50% of *** a day (50% of Part A Coinsurance) ◆ All costs
BLOOD First 3 pints Additional amounts	 $0 100%	 50% $0	 50%◆ $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	50% of coinsurance or copayments	50% of Medicare copayment/coinsurance ◆

PLAN K

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

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts 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.**

** The amount that Medicare does not pay is subject to change. For the current amount that Medicare does not pay, 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.

**** Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (which are noted with an asterisk), your Part B Deductible will have been met for the 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 coinsurance 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.

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 portion of Medicare-approved amounts**** Preventive Benefits for Medicare-covered services Remainder of Medicare-approved amounts	 $0 Generally 80% or more of Medicare-approved amounts Generally 80%	 $0 Remainder of Medicare-approved amounts Generally 10%	 (Part B Deductible) ****◆ All costs above Medicare-approved amounts Generally 10%◆
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
BLOOD First 3 pints Next portion of Medicare-approved amounts ****	 $0 $0	 50% $0	 50%◆ (Part B Deductible) ****◆
Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10%◆
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN K

PARTS A & B

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts 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.

** The amount that Medicare does not pay is subject to change. For the current amount that Medicare does not pay, 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.

***** 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 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 coinsurance 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.

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

PLAN L

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

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

** 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.

*** The amount that Medicare does not pay is subject to change. For the current amount that Medicare does not pay, 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.

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

◆ 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 coinsurance 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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but ***	(75% of Part A Deductible)	(25% of Part A Deductible)◆
61st thru 90th day	All but *** a day	*** a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but *** a day	*** a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0****
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but *** a day	Up to 75% of *** a day (75% of Part A Coinsurance)	Up to 25% of *** a day (25% of Part A Coinsurance) ◆
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	75%	25%◆
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	75% of copayment/ coinsurance	25% of copayment/ coinsurance ◆

PLAN L

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

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts 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.**

** The amount that Medicare does not pay is subject to change. For the current amount that Medicare does not pay, 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.

**** Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (which are noted with an asterisk), your Part B Deductible will have been met for the 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 coinsurance 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.

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 portion of Medicare-approved amounts ****	$0	$0	(Part B Deductible) ****◆
Preventive Benefits for Medicare-covered services	Generally 80% 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 (and they do not count toward annual out-of-pocket limit)*
BLOOD			
First 3 pints	$0	75%	25%◆
Next portion of Medicare-approved amounts ****	$0	$0	(Part B Deductible)◆
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%◆
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN L

PARTS A & B

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts 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.

** The amount that Medicare does not pay is subject to change. For the current amount that Medicare does not pay, please consult the most current version of the *Guide to Health for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

***** 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 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 coinsurance 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.

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

PLAN M

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.

** The amount that Medicare does not pay is subject to change. For the current amount that Medicare does not pay, 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.

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

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

PLAN M

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

* Once you have been billed a portion of Medicare-approved amounts ~~(()~~ equal to the Part B Deductible ~~())~~ 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 portion of Medicare-approved amounts*	$0	$0	(Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next portion of Medicare-approved amounts*	$0	$0	(Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN M

PARTS A & B

* Once you have been billed a portion of Medicare-approved amounts ~~[(]~~ equal to the Part B Deductible ~~[)]~~ for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

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

PLAN M

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

PLAN N

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.

** The amount that Medicare does not pay is subject to change. For the current amount that Medicare does not pay, 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.

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

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

PLAN N

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

* Once you have been billed a portion of Medicare-approved amounts ~~(~~ equal to the Part B Deductible ~~)~~ for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

** The amount that Medicare does not pay is subject to change. For the current amount that Medicare does not pay, 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
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 portion of Medicare-approved amounts* Remainder of Medicare-approved amounts	 $0 Generally 80%	 $0 Balance, other than up to ** per office visit and up to ** per emergency room visit. The copayment of up to ** is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	 (Part B Deductible) Up to ** per office visit and up to ** per emergency room visit. The copayment of up to ** is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs

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

PLAN N

PARTS A & B

* Once you have been billed a portion of Medicare-approved amounts ~~[(]~~ equal to the Part B Deductible ~~[)]~~ 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 portion of Medicare-approved amounts* Remainder of Medicare-approved amounts	 100% $0 80%	 $0 $0 20%	 $0 (Part B Deductible) $0

PLAN N

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

Sec. 14. NAC 687B.322 is hereby amended to read as follows:

687B.322 1. In addition to the standards set forth in NAC 687B.323, the standards provided for in this section are:

(a) ~~[Applicable]~~ ***Except as otherwise provided in section 6 of this regulation, applicable*** to all policies to supplement Medicare or certificates delivered or issued for delivery in this State with an effective date for coverage on or after June 1, 2010; and

(b) Not applicable to policies to supplement Medicare or certificates delivered or issued for delivery in this State with an effective date for coverage before June 1, 2010.

2. On or after June 1, 2010, the following standards apply to policies to supplement Medicare and certificates and are in addition to all other requirements:

(a) A policy to supplement Medicare or a certificate must not:

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

(2) 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.

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

(b) 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, copayment or coinsurance amounts. Premiums may be modified to correspond with such changes.

(c) No policy to supplement Medicare or certificate may provide for the 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.

(d) A policy to supplement Medicare must be guaranteed renewable and:

(1) The issuer shall not cancel or fail to renew the policy solely because of the health status of the person.

(2) The issuer shall not cancel or fail to renew the policy for any other reason than the nonpayment of premiums or for a material misrepresentation.

(e) If a policy to supplement Medicare is terminated by the group policyholder and is not replaced as provided under paragraph (g), the issuer shall offer to each certificate holder an individual policy to supplement Medicare which, at the option of the certificate holder:

(1) Provides for the continuation of the benefits contained in the group policy; or

(2) Provides benefits that otherwise meet the requirements of this subsection.

(f) If a person is a certificate holder in a group policy to supplement Medicare and the person terminates membership in the group, the issuer shall:

(1) Offer the certificate holder the conversion opportunity described in paragraph (e); or

(2) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(g) If a group policy to supplement Medicare is replaced by another group policy to supplement Medicare which is purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage under the new policy must not result in the exclusion of coverage for preexisting conditions that would have been covered under the group policy being replaced.

(h) 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 conditioned 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. The receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(i) A policy to supplement Medicare or a certificate must provide that benefits and premiums under the policy or certificate must be suspended at the request of the policyholder or certificate

holder for the period, not to exceed 24 months, during which the policyholder or certificate 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 policyholder or certificate holder notifies the issuer of the policy or certificate within 90 days after the date the person becomes eligible for such assistance. If benefits or premiums are suspended and the policyholder or certificate holder loses eligibility for such medical assistance, the policy or certificate must be automatically reinstated effective as of the date eligibility is terminated if the policyholder or certificate holder provides notice of loss of eligibility to the insurer within 90 days after the date of loss and pays the premium attributable to the period of eligibility.

(j) A policy to supplement Medicare or a certificate must provide that benefits and premiums under the policy must be suspended at the request of the policyholder for any period that may be provided by federal regulation if the policyholder is entitled to benefits under section 226(b) of the Social Security Act, 42 U.S.C. § 426(b), and is covered under a group health plan as 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 and the policyholder or certificate holder loses coverage under the group health plan, the policy must be automatically reinstated, effective as of the date of loss of coverage if the policyholder provides notice of loss of coverage within 90 days after the date of the loss and pays the premium attributable to the period.

(k) Reinstatement of coverage as described in paragraphs (i) and (j):

(1) Must not provide for any waiting period with respect to treatment of preexisting conditions;

(2) Must provide for resumption of coverage that is substantially equivalent to the coverage in effect before the premiums and benefits were suspended; and

(3) Must provide for the classification of premiums on terms at least as favorable to the policyholder or certificate holder as the terms in effect before the benefits and premiums were suspended.

3. On or after June 1, 2010, every issuer shall make available a policy or certificate which includes a basic core package of benefits to each prospective insured, but an issuer may make available to prospective insureds any of the other benefit plans to supplement Medicare in addition to, but not in lieu of, the basic core package. The basic core package of benefits must consist of:

(a) Coverage of Part A Medicare 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 of Part A Medicare eligible expenses incurred for hospitalization to the extent 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 applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days, and the provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

(d) Coverage under Medicare Parts A and B for 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.

(e) Coverage for the coinsurance amount, or, in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible

expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

(f) Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

4. On or after June 1, 2010, the following additional benefits must be included in Standardized Benefit Plans B, C, D, F, F with High Deductible, G, ***G with High Deductible,*** M and N to supplement Medicare as provided by NAC 687B.323 ~~[:]~~ ***and section 6 of this regulation:***

(a) Coverage for 100 percent of the Medicare Part A inpatient hospital deductible amount per benefit period;

(b) Coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period;

(c) Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A;

(d) ~~[Coverage]~~ ***Except as otherwise provided in sections 5 and 6 of this regulation, coverage*** for 100 percent of the Medicare Part B deductible amount per calendar year regardless of hospital confinement;

(e) Coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Part B charge approved by Medicare; and

(f) Coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare eligible expenses for medically necessary emergency hospital, physician and medical

care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this paragraph, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

Sec. 15. NAC 687B.323 is hereby amended to read as follows:

687B.323 1. In addition to the standards set forth in NAC 687B.322, the standards provided for in this section are:

(a) ~~[Applicable]~~ ***Except as otherwise provided in section 6 of this regulation, applicable*** to all policies to supplement Medicare or certificates delivered or issued for delivery in this State with an effective date for coverage on or after June 1, 2010; and

(b) Not applicable to policies to supplement Medicare or certificates delivered or issued for delivery in this State with an effective date for coverage before June 1, 2010.

2. On or after June 1, 2010, an issuer shall make available to each prospective policyholder or certificate holder a policy form or certificate form containing only the basic core benefits, as set forth in subsection 3 of NAC 687B.322.

3. ~~[On]~~ ***Except as otherwise provided in section 6 of this regulation, on*** or after June 1, 2010, if an issuer makes available any of the additional benefits set forth in subsection 4 of NAC 687B.322, or offers Standardized Benefit Plan K or L as described in paragraphs (h) and (i) of subsection 7, the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic core benefits as described in subsection 2, a policy form or certificate form containing either Standardized

Benefit Plan C as described in paragraph (c) of subsection 7 or Standardized Benefit Plan F as described in paragraph (e) of subsection 7.

4. ~~[On]~~ ***Except as otherwise provided in section 6 of this regulation, on*** or after June 1, 2010, no group, package or combinations of benefits to supplement Medicare other than those listed in this section may be offered for sale in this State, except as may be permitted in subsection 8 and in NAC 687B.340 to 687B.376, inclusive.

5. ~~[On]~~ ***Except as otherwise provided in section 6 of this regulation, on*** or after June 1, 2010 ~~[, a]~~ ***:***

(a) A benefit plan must be uniform in structure, language, designation and format to the standardized benefit plans listed in this section and must conform to the definition in NAC 687B.2003 ~~[.]~~ ***or section 2 of this regulation, as applicable;***

(b) Each benefit must be structured in accordance with the format provided in subsections 3 and 4 of NAC 687B.322 or, in the case of Standardized Benefit Plan K or L, in paragraphs (h) and (i) of subsection 7, and list the benefits in the order shown in the applicable requirements.

6. On or after June 1, 2010, and in addition to the benefit plans required in subsection 5, an issuer may use other designations to the extent permitted by law.

7. On or after June 1, 2010, the contents of standardized benefit plans must be as follows:

(a) A 2010 standardized benefit plan to supplement Medicare ***, or a 2020 standardized benefit plan to supplement Medicare,*** which is designated as Standardized Benefit Plan A must include only the basic core benefits as defined in subsection 3 of NAC 687B.322.

(b) A 2010 standardized benefit plan to supplement Medicare ***, or a 2020 standardized benefit plan to supplement Medicare,*** which is designated as Standardized Benefit Plan B must include only the basic core benefits as defined in subsection 3 of NAC 687B.322, plus 100

percent of the Medicare Part A deductible as defined in paragraph (a) of subsection 4 of NAC 687B.322.

(c) A 2010 standardized benefit plan to supplement Medicare which is designated as Standardized Benefit Plan C must include only the basic core benefits as defined in subsection 3 of NAC 687B.322, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in paragraphs (a), (c), (d) and (f) of subsection 4 of NAC 687B.322, respectively. ***A Standardized Benefit Plan C is not available for a 2020 standardized benefit plan to supplement Medicare.***

(d) A 2010 standardized benefit plan to supplement Medicare ***, or a 2020 standardized benefit plan to supplement Medicare,*** which is designated as Standardized Benefit Plan D must include only the basic core benefits as defined in subsection 3 of NAC 687B.322, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs (a), (c) and (f) of subsection 4 of NAC 687B.322, respectively.

(e) A 2010 standardized benefit plan to supplement Medicare which is designated as Standardized Benefit Plan F must include only the basic core benefits as defined in subsection 3 of NAC 687B.322, plus 100 percent of the Medicare Part A deductible, the skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (a), (c), (d), (e) and (f) of subsection 4 of NAC 687B.322, respectively. ***A Standardized Benefit Plan F is not available for a 2020 standardized benefit plan to supplement Medicare.***

(f) A 2010 standardized benefit plan to supplement Medicare***, or, except as otherwise provided in section 6 of this regulation, a 2020 standardized benefit plan to supplement Medicare,*** which is designated as High Deductible Benefit Plan F:

(1) Must include only 100 percent of covered expenses following the payment of the annual deductible set forth in subparagraph (2) and the basic core benefits as defined in subsection 3 of NAC 687B.322, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (a), (c), (d), (e) and (f) of subsection 4 of NAC 687B.322, respectively; and

(2) Has an annual deductible that:

(I) Must consist of out-of-pocket expenses, other than premiums, for services covered by Standardized Benefit Plan F.

(II) Must be in addition to any other specific benefit deductibles; and

(III) Has a base which must be $1,500 and must be adjusted annually from 1999 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 for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

(g) A 2010 standardized benefit plan to supplement Medicare ***, or a 2020 standardized benefit plan to supplement Medicare,*** which is designated as Standardized Benefit Plan G must include only the basic core benefits as defined in subsection 3 of NAC 687B.322, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (a), (c), (e) and (f) of subsection 4 of NAC 687B.322, respectively.

(h) A 2010 standardized benefit plan to supplement Medicare ***, or a 2020 standardized benefit plan to supplement Medicare,*** which is designated as Standardized Benefit Plan K is mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, 117 Stat. 2066, December 8, 2003, and must include:

(1) Coverage of 100 percent of the Medicare Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

(2) Coverage of 100 percent of the Medicare Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

(3) 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 applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days, and the provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(4) 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 subparagraph (10);

(5) 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 posthospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subparagraph (10);

(6) 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 subparagraph (10);

(7) 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 subparagraph (10);

(8) Except for coverage provided in subparagraph (9), 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 subparagraph (10);

(9) Coverage of 100 percent of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

(10) 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 the United States Department of Health and Human Services.

(i) A 2010 standardized benefit plan to supplement Medicare ***, or a 2020 standardized benefit plan to supplement Medicare,*** which is designated as Standardized Benefit Plan L is mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, 117 Stat. 2066, December 8, 2003, and must include only the following:

(1) The benefits described in subparagraphs (1), (2), (3) and (9) of paragraph (h);

(2) The benefits described in subparagraphs (4) to (8), inclusive, of paragraph (h), but substituting 75 percent for 50 percent; and

(3) The benefit described in subparagraph (10) of paragraph (h), but substituting $2,000 for $4,000.

(j) A 2010 standardized benefit plan to supplement Medicare ***, or a 2020 standardized benefit plan to supplement Medicare,*** which is designated as Standardized Benefit Plan M must include only the basic core benefits as defined in subsection 3 of NAC 687B.322, plus 50 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs (b), (c) and (f) of subsection 4 of NAC 687B.322, respectively.

(k) A 2010 standardized benefit plan to supplement Medicare ***, or a 2020 standardized benefit plan to supplement Medicare,*** which is designated as Standardized Benefit Plan N must include only the basic core benefits as defined in subsection 3 of NAC 687B.322, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care and medically necessary emergency care in a foreign country as defined in paragraphs (a), (c) and (f) of subsection 4 of NAC 687B.322, respectively, with coinsurance or copayments in the following amounts:

(1) The lesser of $20 or the Medicare Part B coinsurance or copayment for each covered health care provider office visit, including visits to medical specialists; and

(2) The lesser of $50 or the Medicare Part B coinsurance or copayment for each covered emergency room visit. This coinsurance or copayment must be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

8. On or after June 1, 2010, 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 standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards, and:

(a) The new or innovative benefits must include only benefits that are appropriate to insurance to supplement Medicare, are new or innovative, are not otherwise available and are cost-effective;

(b) Approval of new or innovative benefits must not adversely impact the goal of simplifying policies to supplement Medicare;

(c) New or innovative benefits must not include an outpatient prescription drug benefit; and

(d) New or innovative benefits must not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized benefit plan.

9. As used in this section, "structure, language, designation and format" means style, arrangement and overall content of a benefit.