PROPOSED REGULATION OF THE COMMISSIONER OF INSURANCE

LCB File No. R041-17

PROPOSED PERMANENT REGULATION CONCERNING
MEDICARE SUPPLEMENT PLANS

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

AUTHORITY: §§1-2, NRS 679B.130 and 687B.430.

A REGULATION relating to insurance; defining "2020 Standardized benefit plan to supplement Medicare;" revising various standards for Medicare supplement policies and certificates; creating new plans related to Medicare supplement policies and certificates; deleting various plans related to Medicare supplement policies and certificates; and providing other matters properly relating thereto.

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

Sec. 2. "2020 Standardized benefit plan to supplement Medicare" or "2020 Standardized benefit plan" means a policy to supplement Medicare issued with an effective date for coverage on or after January 1, 2020.

Sec. 3. "Newly eligible" means anyone who:

1. Attains age 65 on or after January 1, 2020, or

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

Sec. 4. 1. On or after January 1, 2020, 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 sections 5 - 7 of this regulation.

2. No issuer may offer any 2010 standardized benefit plan to supplement Medicare for sale on or after January 1, 2020.

3. Benefits standards applicable to a policy to supplement Medicare or a certificate issued with an effective date for coverage before January 1, 2020, remain subject to the requirements of NAC 687B.2003, NAC 687B.2273, NAC 687B.250, NAC 687B.322 and NAC 687B.323.

Sec. 5. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires the following standards to be applicable to all policies to supplement Medicare or certificates delivered or issued for delivery in this State to individuals newly eligible for Medicare on or after January 1, 2020. No policy or certificate that provides coverage of the Medicare Part B deductible may be advertised, solicited, delivered or issued for delivery in this State as a policy to supplement Medicare or certificate to individuals newly eligible for Medicare on or after January 1, 2020. All policies must comply with the following benefit standards. Benefit plan standards applicable to policies to supplement Medicare and certificates issued to individuals eligible for Medicare before January 1, 2020, remain subject to the requirements of NAC 687B.2003, NAC 687B.2273, NAC 687B.250, NAC 687B.322 and NAC 687B.323.

1. Benefit Requirements. The standards and requirements of NAC 687B.250, NAC 687B.322 and NAC 687B.323 shall apply to all Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020, with the following exceptions:

(a) Standardized Medicare supplement benefit Plan C is redesignated as Plan D and shall provide the benefits contained in paragraph (c) of subsection 7 of NAC 687B.323 but shall

not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible.

(b) Standardized Medicare supplement benefit Plan F is redesignated as Plan G and shall provide the benefits contained in paragraph (e) of subsection 7 of NAC 687B.323 but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible.

(c) Standardized Medicare supplement benefit plans C, F, and F with High Deductible may not be offered to individuals newly eligible for Medicare on or after January 1, 2020.

(d) Standardized Medicare supplement benefit Plan F With High Deductible is redesignated as Plan G With High Deductible and shall provide the benefits contained in paragraph (f) of subsection 7 of NAC 687B.323 but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible; provided further that, the Medicare Part B deductible paid by the beneficiary shall be considered an out-of-pocket expense in meeting the annual high deductible.

(e) The reference to Plans C or F contained in subsection 3 of NAC 687B.323 is deemed a reference to Plans D or G for purposes of this section.

2. Applicability to Certain Individuals. Section 6 of this regulation applies to only individuals that are newly eligible for Medicare on or after January 1, 2020:

(a) by reason of attaining age 65 on or after January 1, 2020; or

(b) by reason of entitlement to benefits under part A pursuant to section 226(b) or 226A of the Social Security Act, or who is deemed to be eligible for benefits under section 226(a) of the Social Security Act on or after January 1, 2020.

3. Guaranteed Issue for Eligible Persons. For purposes of NAC 687B.2057, in the case of any individual newly eligible for Medicare on or after January 1, 2020, any reference to a Medicare supplement policy C or F (including F With High Deductible) shall be deemed to be a reference to Medicare supplement policy D or G (including G With High Deductible) respectively that meet the requirements of this subjection 1 of Section 6 of this regulation

4. Applicability to Waivered States. In the case of a State described in Section 1882(p)(6) of the Social Security Act ("waivered" alternative simplification states) MACRA prohibits the coverage of the Medicare Part B deductible for any Medicare supplement policy sold or issued to an individual that is newly eligible for Medicare on or after January 1, 2020.

5. Offer of Redesignated Plans to Individuals Other Than Newly Eligible. On or after January 1, 2020, the standardized benefit plans described in paragraph (d) of subjection 1 of Section 6, above may be offered to any individual who was eligible for Medicare prior to January 1, 2020 in to the standardized plans described in subsection 7 of NAC 687B.323.

Sec. 6. NAC 687B.250 is hereby amended to read as follows:

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

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

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

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

(a) A cover page;

(b) Information regarding premiums;

(c) Disclosure pages; and

(d) Charts displaying the features of each benefit plan offered by the issuer as set forth in subsection 7.

4. 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 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

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.

PREMIUM INFORMATION (Boldface type)

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

DISCLOSURES (Boldface type)

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

(Boldface type)

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

Benefit Chart of Medicare Supplement Plans Sold 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 co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

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

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	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 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	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	$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 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
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

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

PLAN D

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

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

** 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 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 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

PLAN F or HIGH DEDUCTIBLE PLAN F

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

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	Up to ** 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 co-payment/coinsurance for out- patient drugs and inpatient respite care	Medicare co-payment/ 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 (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
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 (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 USA			
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 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* Remainder of Medicare-approved amounts	 $0 Generally 80%	 (Part B Deductible) Generally 20%	 $0 $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 (Part B Deductible) 20%	 $0 $0 $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* Remainder of Medicare-approved amounts	 $0 Generally 80%	 (Part B Deductible) Generally 20%	 $0 $0
Part B Excess Charges (Above Medicare-approved amounts)	$0	100%	$0

SERVICES	MEDICARE PAYS	AFTER YOU PAY THE DEDUCTIBLE, PLAN PAYS **	IN ADDITION TO THE DEDUCTIBLE, YOU PAY **
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 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 days in a row.

** 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.

**** This high deductible plan pays the same benefits as 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 co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/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 (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.)
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 Next portion of Medicare-approved amounts* Remainder of Medicare-approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 (Part B Deductible, unless Part B Deductible has been met.) $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 (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 USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

~~PLAN G~~

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

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

~~** 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 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	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 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	$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
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 50% of *** a day (50% of Part A Coinsurance)	Up to 50% of *** a day (50% of Part A Coinsurance) ◆
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50%◆
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	50% 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 ****	$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 10%	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)
BLOOD			
First 3 pints	$0	50%	50%◆
Next portion of Medicare-approved amounts ****	$0	$0	(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	100%	$0	$0
Durable medical equipment:			
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

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

Sec. 7. 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 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 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 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 or after June 1, 2010, 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**. 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 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 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.

(d) A 2010 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.

(f) A 2010 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 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. Effective January 1, 2020, the standardized benefit plans described in Section 6(1)(d) of this regulation (Redesignated Plan G High Deductible) may be offered to any individual who was eligible for Medicare prior to January 1, 2020.

(h) A 2010 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 post hospital 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 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 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 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.

Sec. 8. This regulation becomes effective on December 31, 2017.