LCB File No. R075-02

PROPOSED REGULATION OF THE COMMISSIONER OF INSURANCE

NOTICE OF WORKSHOPS TO SOLICIT COMMENTS ON PROPOSED REGULATIONS

May 24, 2002

The Department of Business and Industry, Division of Insurance (Division) is proposing new regulations pertaining to the Essential Insurance Association, Medicare Supplement Policies, Bail Advertising, Prohibition of Discretionary Clauses in Health Insurance Plans, Audited Financial Reports, Dental Care and Policies of Health Insurance, and Multiple Employer Welfare Arrangements. A workshop has been set for 9:00 a.m., on June 28, 2002, at the offices of the Division, 788 Fairview Drive, Suite 300, Carson City, Nevada 89701. Interested parties may also participate through a simultaneous video-conference conducted at the Bradley Building, 2501 E. Sahara Avenue, Manufactured Housing Division Conference Room, 2nd Floor, Las Vegas, Nevada 89104. The purpose of the workshop is to solicit comments from interested persons on the following general topics addressed in the proposed regulations.

1. **Essential Insurance Association: Proposed regulation is to replace the emergency regulation of March 15, 2002, establishing the Medical Liability Association of Nevada, a Nevada Essential Insurance Association. Emergency regulations are effective for only a period of 120 days.**

2. **Medicare Supplement Policies: Proposed regulation amends the requirements placed on insurers of Medicare Supplement policies to conform with federal laws. As a result of the federal passage of the Benefits Improvement and Protection Act and the Ticket to Work Act, coverage under Medicare has been modified. Changes to Medicare effects coverage under Medicare Supplement policies. The proposed changes to the Medicare Supplement regulations incorporate the federal changes.**

3. **Bail Advertising: Proposed regulation adds language to ensure that the public is protected from deceptive or misleading advertising specifically related to bail transactions.**

4. **Prohibition of Discretionary Clause in Health Insurance Plans: The proposed regulation prohibits a health carrier from issuing a policy, contract, certificate or agreement that contains a provision reserving discretion to the health carrier to interpret the terms of the contract, unless the carrier fully discloses all the rights available to the policyholder in the event of a dispute.**

5. **Audited Financial Reports: Proposed regulation updates certain requirements of insurers to register its independent certified public accountant with the Commissioner of Insurance and provides for the Commissioner of Insurance to not recognize an**

independent certified public accountant which has either directly or indirectly entered into an agreement of indemnity with respect to the audit of the insurer.

6. **Dental Care and Polices of Health Insurance: Proposed regulation states that a health insurance policy that provides coverage for anesthesia in a hospital or out-patient setting must not deny coverage for anesthesia provided during certain dental procedures.**

7. **Multiple Employer Welfare Arrangements: Proposed regulation requires multiple employer welfare arrangements to meet the qualifications as any domestic insurer, set forth in Chapter 680A of the NRS.**

Members of the insurance industry, business community, and the public are also invited to comment on any impact the proposed regulations may have on small businesses. The Division has reviewed the proposed regulations and determined that the regulations do not impose a direct or significant impact on a small business, or directly restrict the formation, operation, or expansion of a small business.

A copy of this notice and the proposed regulations will be on file at the State Library, 100 Stewart Street, Carson City, Nevada, for inspection by members of the public during business hours. Additional copies of the notice and the proposed regulations will be available at the offices of the Division, 788 Fairview Drive, Suite 300, Carson City, Nevada 89701, and 2501 East Sahara Avenue, Suite 302, Las Vegas, Nevada 89104, and in all counties in which an office of the agency is not
maintained, at the main public library, for inspection and copying by members of the public during business hours. This notice and the text of the proposed regulations are also available in the **State of Nevada Register of Administrative Regulations** which is prepared and published monthly by the Legislative Counsel Bureau pursuant to NRS 233B.0653 and on the Internet at **www.leg.state.nv.us**. Copies will also be mailed to members of the public upon request. A reasonable fee may be charged for copies if it is deemed necessary.

This Notice of Workshop to Solicit Comments on Proposed Regulations has been sent to all persons on the agency's mailing list for administrative regulations and posted at the following locations:

Department of Business and Industry
Division of Insurance
788 Fairview Drive, Suite 300
Carson City, NV 89701

Department of Business and Industry
Division of Insurance
2501 East Sahara Avenue, Suite 302
Las Vegas, NV 89104

Legislative Counsel Bureau
Capitol Complex
Carson City, NV 89710

Blasdel Building
Capitol Complex
Carson City, NV 89710

State Capitol
Capitol Complex
Carson City, NV 89710

Capitol Press Room
State Capitol Basement
Carson City, NV 89710

County Clerk
Courthouse
Carson City, NV 89710

Carson City Library
900 North Roop Street
Carson City, NV 89701

Las Vegas Library
833 Las Vegas Blvd. North
Las Vegas, NV 89101

Elko County Library
720 Court Street
Elko, NV 89801

Eureka Branch Library
10190 Monroe Street
P.O. Box 293
Eureka, NV 89316

Battle Mountain Branch Library
P.O. Box 141
Battle Mountain, NV 89820

Lyon County Library
20 Nevin Way
Yerington, NV 89447

Tonopah Public Library
171 Central Street
P.O. Box 449
Tonopah, NV 89049

Storey County Library
95 South R Street
P.O. Box 14
Virginia City, NV 89440

White Pine County Library
950 Campton Street
Ely, NV 89301

Nevada State Library & Archives
Capitol Complex
Carson City, NV 89710

Churchill County Library
553 South Maine Street
Fallon, NV 89406

Douglas County Library
1625 Library Lane
P.O. Box 337
Minden, NV 89423

Goldfield Public Library
Fourth & Cook Street
P.O. Box 430
Goldfield, NV 89013

Humboldt County Library
85 East 5th Street
Winnemucca, NV 89445

Lincoln County Library
93 Main Street
P.O. Box 330
Pioche, NV 89043

Mineral County Library
First & A Street
P.O. Box 1390
Hawthorne, NV 89415

Pershing County Library
1125 Central Avenue
P.O. Box 781
Lovelock, NV 89419

Washoe County Library
301 South Center Street
P.O. Box 2151
Reno, NV 89505

Clark County Library
1401 East Flamingo Road
Las Vegas, NV 89119

Members of the public who are disabled and require special accommodations or assistance at the hearing are requested to notify the Commissioner's secretary in writing at 788 Fairview Drive, Suite 300, Carson City, Nevada 89701, or by calling no later than 5 working days prior to the hearing, (775) 687-4270, extension 260.

DATED this _____ day of May, 2002.

By: _____
ALICE A. MOLASKY-ARMAN
Commissioner of Insurance

NOTICE OF INTENT TO ACT UPON REGULATIONS

Notice of Hearing for the Adoption of Regulations of the Department of Business and Industry, Division of Insurance

The Department of Business and Industry, Division of Insurance (Division) will hold a public hearing at 9:00 a.m., on June 28, 2002, immediately following a public workshop, at the offices of the Division, 788 Fairview Drive, Suite 300, Carson City, Nevada 89701. Interested persons may also participate through a simultaneous video-conference conducted at the Bradley Building, 2501 East Sahara Avenue, Manufactured Housing Division conference Room, Second Floor, Las Vegas, Nevada 89104. The purpose of the hearing is to receive comments from all interested persons regarding the adoption of regulations pertaining to dental care and health insurance.

AMENDMENT TO REGULATIONS CONCERNING POLICIES OF INSURANCE TO SUPPLEMENT MEDICARE

The following information is provided pursuant to the requirements of NRS 233B.060:

1. The proposed regulation is needed to maintain conformity with federal standards on medicare supplement plans.

2. The regulation amends the eligibility to apply for guaranteed issue policies for enrollees of Medicare + Choice plans which terminate; allows for the suspension of coverage when the policyholder becomes covered under an employer plan as a result of the Ticket to Work Act; allows for an alternative payment procedure as a result of the federal outpatient prospective payment system; clarifies the guaranteed issue eligibility dates for individuals whose employer plans have been terminated; and other changes as a result of changes to Medicare coverage.

3. Estimated economic effect of the regulation:
   <u>On the business which it is to regulate:</u>
   The proposed regulation may have a minimal impact on the industry.
   <u>On the public:</u>
   The proposed regulations may have a minimal economic impact on the public.

4. The Division will not incur additional expense to enforce the proposed regulation.

5. This regulation dovetails with changes in federal requirements and guidelines for Medicare Supplement policies. The federal regulatory agency responsible for Medicare and establishing standards for Medicare Supplement policies would be the Department of Health and Human Services, Centers for Medicare and Medicaid Services.

6. The proposed regulation does not establish any new fees or increase an existing fee.

Persons wishing to comment upon the proposed action of the Division may appear at the scheduled public hearing or may address their comments, data, views or arguments, in written form, to the Division, 788 Fairview Drive, Suite 300, Carson City, Nevada 89701. Written

submissions must be received by the Division on or before June 21, 2002. If no person who is directly affected by the proposed action appears to request time to make an oral presentation, the Division may proceed immediately to act upon any written submissions.

A copy of this notice and the proposed regulation will be on file at the State Library, 100 Stewart Street, Carson City, Nevada, for inspection by members of the public during business hours. Additional copies of the notice and the regulation to be amended will be available at the offices of the Division, 788 Fairview Drive, Suite 300, Carson City, Nevada 89701, and 2501 East Sahara Avenue, Suite 302, Las Vegas, Nevada 89104, and in all counties in which an office of the agency is not maintained, at the main public library, for inspection and copying by members of the public during business hours. This notice and the text of the proposed regulation are also available in the State of Nevada Register of Administrative Regulations which is prepared and published monthly by the Legislative Counsel Bureau pursuant to NRS 233B.0653 and on the Internet at **http://www.leg.state.nv.us**. Copies will also be mailed to members of the public upon request. A reasonable fee may be charged for copies if it is deemed necessary.

Upon adoption of any regulation, the agency, if requested to do so by an interested person, either before adoption or within 30 days thereafter, will issue a concise statement of the principal reasons for and against its adoption, and incorporate therein its reason for overruling the consideration urged against its adoption.

This notice of hearing has been posted at the following locations:

Department of Business and Industry
Division of Insurance
788 Fairview Drive, Suite 300
Carson City, NV 89701

Department of Business and Industry
Division of Insurance
2501 East Sahara Avenue, Suite 302
Las Vegas, NV 89104

Legislative Counsel Bureau
Capitol Complex
Carson City, NV 89710

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Fallon, NV 89406

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Minden, NV 89423

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Elko, NV 89801

Eureka Branch Library
10190 Monroe Street
P.O. Box 293
Eureka, NV 89316

Battle Mountain Branch Library
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Battle Mountain, NV 89820

Mineral County Library
First & A Street
P.O. Box 1390
Hawthorne, NV 89415

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P.O. Box 449
Tonopah, NV 89049

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P.O. Box 14
Virginia City, NV 89440

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Ely, NV 89301

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P.O. Box 430
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Winnemucca, NV 89445

Lincoln County Library
93 Main Street
P.O. Box 330
Pioche, NV 89043

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Yerington, NV 89447

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1125 Central Avenue
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Lovelock, NV 89419

Washoe County Library
301 South Center Street
P.O. Box 2151
Reno, NV 89505

Clark County Library
1401 East Flamingo Road
Las Vegas, NV 89119

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DATED this _____ day of May, 2002.

_____
ALICE A. MOLASKY-ARMAN
Commissioner of Insurance

PROPOSED REGULATION OF THE COMMISSIONER OF INSURANCE

REGULATIONS CONCERNING POLICIES OF INSURANCE TO SUPPLEMENT MEDICARE

Authority: NRS 679B.130.

Section 1. Chapter 687B of NAC is amended by adding thereto the provisions set forth in sections 2 to 10 of this regulation.

Sec. 2. NAC 687B.2034 is hereby amended to read as follows:

"Medicare + Choice plan" means a plan of ~~[health insurance established by the program set forth in sections 1851 to 1859, inclusive, of the Social Security Act, 42 U.S.C. §§ 1395w21 to –28, inclusive.]~~ ***coverage for health benefits under Medicare Part C as defined in U.S.C. §§ 1395w-28(b)(1), and includes:***

1. Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;

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

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

Sec. 3. NAC 687B.206 is hereby amended to read as follows:

Eligibility for policy to supplement Medicare offered to new enrollees or for certificate offered to new enrollees: Evidence of disenrollment within previous 63 days from certain plans under certain circumstances. (NRS 679B.130, 687B.430)

1. A person is eligible for a policy to supplement Medicare that is offered to new enrollees or for a certificate that is offered to new enrollees***, subject to paragraphs (f and g), below*** ~~[if he provides evidence that he disenrolled within the previous 63 days from]~~:

(a) An employee welfare benefit plan that:

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

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

(b) An employee welfare benefit plan that:

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

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

(c) A Medicare + Choice plan offered by a Medicare + Choice organization pursuant to Medicare Part C, if the person was allowed to disenroll from the Medicare + Choice plan under any of the following circumstances ***or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare + Choice plan***:

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

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

(~~[2]~~***3***) The person was no longer eligible to elect a Medicare + Choice plan because:

(I) His residence changed;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) The insurer involuntarily terminated coverage or enrollment;

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

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

(f) (1) In the case of an individual making the election described in subparagraphs (a) and (b), the guaranteed issue period begins on the later of: (i) the date the individual receives a notice of termination or cessation of substantially all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of such a termination or cessation); or (ii) the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter;

(2) In the case of an individual described in subparagraph c or d whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives notice of termination and ends sixty-three (63) days after the date the applicable coverage is terminated;

(3) In the case of an individual described in subparagraph e, the guaranteed issue period begins on the earlier of: (i) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and (ii) the date that the applicable coverage is terminated, and ends on the date that is sixty-three (63) days after the date the coverage is terminated;

(4) In the case of an individual described in subparagraph c or e who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date.

(g) (1) An individual described in subparagraph (c) may elect to apply this subsection by substituting, for the date of termination of enrollment, the date on which the individual was notified by the Medicare+Choice organization of the impending termination or discontinuance of the Medicare+Choice plan it offers in the area in which the individual resides, but only if the individual disenrolls from the plan as a result of such notification.

(2) In the case of an individual making the election in subparagraph (g)(1) above, the issuer involved shall accept the application of the individual submitted before the date of termination of enrollment, but the coverage under this Subsection shall only become effective upon termination of coverage under the Medicare+Choice plan involved.

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

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

Sec. 4. NAC 687B.2062 is hereby amended to read as follows:

Eligibility for policy to supplement Medicare offered to new enrollees or for certificate offered to new enrollees: Evidence of disenrollment and enrollment for first time; entitlement to policy or certificate with certain benefits. (NRS 679B.130, 687B.430)

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

(a) Disenrolled from such a policy or certificate;

(b) Subsequently enrolled for the first time in:

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

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

(3) Any PACE program under Section 1894 of the Social Security Act; and

(c) ~~[Disenrolled within the previous 63 days from the subsequent plan within 12 months after his enrollment as authorized pursuant to section 1851(e) of the Social Security Act, 42 U.S.C. § 1395w-21(e).]~~***For an individual whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three (63) days from the date the applicable coverage is terminated.***

(d) For an individual whose enrollment is terminated voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date.

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

Sec. 5. NAC 687B.2064 is hereby amended to read as follows:

Eligibility for policy to supplement Medicare offered to new enrollees or for certificate offered to new enrollees: Evidence of disenrollment within previous 63 days from Medicare + Choice plan offered by Medicare + Choice organization pursuant to Medicare Part C; entitlement to policy or certificate under certain circumstances. (NRS 679B.130, 687B.430)

1. A person is eligible for a policy to supplement Medicare that is offered to new enrollees or for a certificate that is offered to new enrollees if he provides evidence that he has disenrolled ***under the circumstances described in paragraph 3*** ~~[within the previous 63 days]~~ from a Medicare + Choice plan offered by a Medicare + Choice organization pursuant to Medicare Part C ***or in a PACE program under Section 1894 of the Social Security Act*** if he:

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

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

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

3. (a) ***For an individual whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three (63) days from the date the applicable coverage is terminated.***

(b) For an individual whose enrollment is terminated voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date.

Sec. 6. NAC 687B.225 is hereby amended to read as follows:

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

2. A policy to supplement Medicare or a certificate must not:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. For the purposes of this section:

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

(b) "Policy to supplement Medicare" means a group or individual policy of accident and sickness insurance, or a subscriber contract of one or more hospital and medical service

associations or health maintenance organizations, that is advertised, marketed or designed primarily as a supplement to the reimbursement provided under Medicare for the hospital, medical or surgical expenses of one or more persons eligible for Medicare by reason of age.

Sec. 7. NAC 687B.226 is hereby amended to read as follows:

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

2. A policy to supplement Medicare or a certificate must not:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8. If a group policy to supplement Medicare or a certificate is replaced by another group policy to supplement Medicare or another certificate which is purchased by the same person, the issuer of the replacement policy or certificate shall offer coverage to all persons who are covered under the policy or certificate that is being replaced on the date it is terminated. The replacement policy or

certificate may not provide for the exclusion of coverage for preexisting conditions that were covered under the policy or certificate that is being replaced.

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

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

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

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

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

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

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

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

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

Sec. 8. NAC 687B.227 is hereby amended to read as follows:

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

2. A policy to supplement Medicare or a certificate must not:

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

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

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

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

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

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

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

7. Benefits and premiums must be suspended at the request of the policyholder or certificate holder for the period, not to exceed 24 months, during which the holder has applied for and is determined to be eligible for medical assistance under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 et seq., if the holder notifies the issuer of the policy or certificate within 90 days after the date he becomes eligible for such assistance.

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

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

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

9. ***Benefits and premiums must be suspended at the request of the policyholder or certificate holder for any period that may be provided by federal regulation, during which the holder is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within 90 days after the date of the loss.***

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

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

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

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

Sec. 9. NAC 687B.240 is hereby amended to read as follows:

Provision for renewal or continuation; acceptance of riders and endorsements; prohibited standards for payment of benefits; disclosure and dissemination of information.

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

(a) Be captioned appropriately;

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

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

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

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

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

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

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

any rider or endorsement added to a policy to supplement Medicare after the date of its issue, or upon reinstatement or renewal, which reduces or eliminates benefits or coverage provided by the policy, requires a signed acceptance by the insured. After the date the policy or certificate is issued, any rider or endorsement that increases benefits or coverage with a concomitant increase in premiums during the term of the policy must be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for such policies to supplement Medicare, or if the increased benefits or coverage are required by law. If an additional premium is charged for benefits provided in connection with riders or endorsements, that premium must be set forth in the policy.

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

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

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

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

(a) Uses the language, format, type size, proportional spacing, bold type and line spacing developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration; and

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

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

Sec. 10. NAC 687B.250 is hereby amended to read as follows:

Outline of coverage. (NRS 679B.130, 687B.430)

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

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

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

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

(a) A cover page;

(b) Information regarding premiums;

(c) Disclosure pages; and

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

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

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

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

(COMPANY NAME)

Outline of Medicare Supplement Coverage - Cover Page
Benefit Plan(s) _____ ~~[insert letter(s) of plan(s) being offered]~~

Medicare supplement insurance can be sold in only ten standard plans plus two high deductible benefit plans. This chart shows the benefits included in each plan. Every company must make available Plan A .

Basic Benefits: Included in All Plans
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (***generally*** 20% of Medicare-approved expenses) ***or, in the case of hospital outpatient department services under a prospective payment system, applicable copayments***.
Blood: First three pints of blood each year.

A	B	C	D	E	F	High Deductible F*	G	H	I	J	High Deductible J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible	Part B Deductible				Part B Deductible	Part B Deductible
					Part B Excess 100%	Part B Excess 100%	Part B Excess 80%		Part B Excess 100%	Part B Excess 100%	Part B Excess 100%
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	At-Home Recovery
								Basic Drugs ($1,250 Limit)	Basic Drugs ($1,250 Limit)	Basic Drugs ($3,000 Limit)	Basic Drugs ($3,000 Limit)
				Preventive Care						Preventive Care	Preventive Care

* The High Deductible Benefit Plans F and J offer benefits similar to the benefits offered by the Standardized Benefit Plans F and J except that the high deductible benefit plans require a higher deductible. For calendar ~~[years of 1998 and 1999]~~ ***year 2002***, the High Deductible Benefit Plans F and J require the insured to pay an annual deductible in the amount of ~~[$1,500]~~ ***$1,580***, and thereafter those plans require the insured to pay an annual deductible that is adjusted by the Commissioner in the manner set forth in subsection 2 of NAC 687B.311. Benefits for the High Deductible Benefit Plans F and J begin after the insured has paid the annual deductible for expenses that would ordinarily be paid by the plans, including, without limitation, the Medicare Part A deductible and the Medicare Part B deductible. The annual deductible must be paid in addition to the premium and in addition to any other deductibles relating to a specific benefit, including, without limitation, the deductible for prescription drugs and the deductible for emergency care received in a foreign country.

PREMIUM INFORMATION (Boldface type)

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

DISCLOSURES (Boldface type)

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY (Boldface type)

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

RIGHT TO RETURN POLICY (Boldface type)

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

POLICY REPLACEMENT (Boldface type)

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

NOTICE (Boldface type)

This policy may not cover all of your medical costs.

(For agents)

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

(For direct response)

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT
(Boldface type)

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

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

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

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but ~~[$764]~~ ***$812***	$0	~~[$764]~~ ***$812*** (Part A Deductible)
61st thru 90th day	All but ~~[$191]~~ ***$203*** a day	~~[$191]~~ ***$203*** a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but ~~[$382]~~ ***$406*** a day	~~[$382]~~ ***$406*** a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~[$95.50]~~ ***$101.50*** a day	$0	Up to ~~[$95.50]~~ ***$101.50*** a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

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

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

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

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but ~~[$764]~~ ***$812***	~~[$764]~~ ***$812*** (Part A Deductible)	$0
61st thru 90th day	All but ~~[$191]~~ ***$203*** a day	~~[$191]~~ ***$203*** a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but ~~[$382]~~ ***$406*** a day	~~[$382]~~ ***$406*** a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~[$95.50]~~ ***$101.50*** a day	$0	Up to ~~[$95.50]~~ ***$101.50*** a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN B

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

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

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

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but ~~[$764]~~ ***$812***	~~[$764]~~ ***$812*** (Part A Deductible)	$0
61st thru 90th day	All but ~~[$191]~~ ***$203*** a day	~~[$191]~~ ***$203*** a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but ~~[$382]~~ ***$406*** a day	~~[$382]~~ ***$406*** a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~[$95.50]~~ ***$101.50*** a day	Up to ~~[$95.50]~~ ***$101.50*** a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN C

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

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

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

PLAN 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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but ~~[$764]~~ ***$812***	~~[$764]~~ ***$812*** (Part A Deductible)	$0
61st thru 90th day	All but ~~[$191]~~ ***$203*** a day	~~[$191]~~ ***$203*** a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but ~~[$382]~~ ***$406*** a day	~~[$382]~~ ***$406*** a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~[$95.50]~~ ***$101.50*** a day	Up to ~~[$95.50]~~ ***$101.50*** a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN D

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

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

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

PLAN D

MEDICARE (PARTS A & B) - (CONTINUED)

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

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

PLAN E

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but ~~[$764]~~ ***$812***	~~[$764]~~ ***$812*** (Part A Deductible)	$0
61st thru 90th day	All but ~~[$191]~~ ***203*** a day	~~[$191]~~ ***$203*** a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but ~~[$382]~~ ***$406*** a day	~~[$382]~~ ***$406*** a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~[$95.50]~~ ***$101.50*** a day	Up to ~~[$95.50]~~ ***$101.50*** a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN E

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

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

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

PLAN E

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but ~~[$764]~~ ***$812***	~~[$764]~~ ***$812*** (Part A Deductible)	$0
61st thru 90th day	All but ~~[$191]~~ ***$203*** a day	~~[$191]~~ ***$203*** a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but ~~[$382]~~ ***$406*** a day	~~[$382]~~ ***$406*** a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~[$95.50]~~ ***$101.50*** a day	Up to ~~[$95.50]~~ ***$101.50*** a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN F

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

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

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

$0

PLAN F

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States:			
First $250 each calendar year	$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.

** High Deductible Benefit Plan F offers benefits similar to the benefits offered by the Standardized Benefit Plan F except that the high deductible benefit plan requires the insured to pay a higher annual deductible. For ~~[the calendar years of 1998 and 1999]~~ ***calendar year 2001***, the High Deductible Benefit Plan F requires the insured to pay an annual deductible in the amount of ~~[$1,500]~~ ***$1,580***, and thereafter the plan requires the insured to pay an annual deductible that is adjusted by the Commissioner in the manner set forth in subsection 2 of NAC 687B.311. Benefits for the High Deductible Benefit Plan F begin after the insured has paid the annual deductible for expenses that would ordinarily be paid by the plan, including, without limitation, the Medicare Part A deductible and the Medicare Part B deductible. The annual deductible must be paid in addition to the premium and in addition to any other deductibles relating to a specific benefit, including, without limitation, the deductible for ~~[prescription drugs and the deductible for]~~ emergency care received in a foreign country.

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~[$1,500]~~ ***$1,580*** DEDUCTIBLE** PLAN PAYS	IN ADDITION TO ~~[$1,500]~~ ***$1,580*** DEDUCTIBLE** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but ~~[$764]~~ ***$812***	~~[$764]~~ ***$812*** (Part A Deductible)	$0
61st thru 90th day	All but ~~[$191]~~ ***$203*** a day	~~[$191]~~ ***$203*** a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but ~~[$382]~~ ***$406*** a day	~~[$382]~~ ***$406*** a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~[$95.50]~~ ***$101.50*** a day	Up to ~~[$95.50]~~ ***$101.50*** a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

HIGH DEDUCTIBLE BENEFIT PLAN F

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

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

** High Deductible Benefit Plan F offers benefits similar to the benefits offered by the Standardized Benefit Plan F except that the high deductible benefit plan requires the insured to pay a higher annual deductible. For ~~[the calendar years of 1998 and 1999]~~ ***calendar year 2001***, the High Deductible Benefit Plan F requires the insured to pay an annual deductible in the amount of ~~[$1,500]~~ ***$1,580***, and thereafter the plan requires the insured to pay an annual deductible that is adjusted by the Commissioner in the manner set forth in subsection 2 of NAC 687B.311. Benefits for the High Deductible Benefit Plan F begin after the insured has paid the annual deductible for expenses that would ordinarily be paid by the plan, including, without limitation, the Medicare Part A deductible and the Medicare Part B deductible. The annual deductible must be paid in addition to the premium and in addition to any other deductibles relating to a specific benefit, including, without limitation, the deductible for ~~[prescription drugs and the deductible for]~~ emergency care received in a foreign country.

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~[$1,500]~~ ***$1,580*** DEDUCTIBLE** PLAN PAYS	IN ADDITION TO ~~[$1,500]~~ ***$1,580*** DEDUCTIBLE** YOU PAY
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First $100 of Medicare-approved amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare-approved amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE BENEFIT PLAN F

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	PARTS A & B MEDICARE PAYS	AFTER YOU PAY ~~[$1,500]~~ ***$1,580*** DEDUCTIBLE** PLAN PAYS	IN ADDITION TO ~~[$1,500]~~ ***$1,580*** DEDUCTIBLE** YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
---Medically necessary skilled care services and medical supplies	100%	$0	$0
---Durable medical equipment: First $100 of Medicare-approved amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare-approved Amounts	80%	20%	$0
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States:			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but ~~[$764]~~ ***$812***	~~[$764]~~ ***$812*** (Part A Deductible)	$0
61st thru 90th day	All but ~~[$191]~~ ***$203*** a day	~~[$191]~~ ***$203*** a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but ~~[$382]~~ ***$406*** a day	~~[$382]~~ ***$406*** a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~[$95.50]~~ ***$101.50*** a day	Up to ~~[$95.50]~~ ***$101.50*** a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN G

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

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

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

PLAN G

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - (cont d)			
AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare-approved a Home Care Treatment Plan:			
--- Benefit for each visit	$0	Actual charges to $40 a visit	Balance
--- Number of visits covered (must be received within 8 weeks of last Medicare-approved visit)	$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
--- Calendar year maximum	$0	$1,600	
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States:			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN H

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but ~~[$764]~~ ***$812***	~~[$764]~~ ***$812*** (Part A Deductible)	$0
61st thru 90th day	All but ~~[$191]~~ ***$203*** a day	~~[$191]~~ ***$203*** a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but ~~[$382]~~ ***$406*** a day	~~[$382]~~ ***$406*** a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~[$95.50]~~ ***$101.50*** a day	Up to ~~[$95.50]~~ ***$101.50*** a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN H

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

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

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

PLAN H

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

PLAN I

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but ~~[$764]~~ ***$812***	~~[$764]~~ ***$812*** (Part A Deductible)	$0
61st thru 90th day	All but ~~[$191]~~ ***$203*** a day	~~[$191]~~ ***$203*** a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but ~~[$382]~~ ***$406*** a day	~~[$382]~~ ***$406*** a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~[$95.50]~~ ***$101.50*** a day	Up to ~~[$95.50]~~ ***$101.50*** a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN I

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

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

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

PLAN I

MEDICARE (PARTS A & B) - (CONTINUED)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - (cont d)			
AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE			
Home care certified by your doctor, For personal care during recovery From an injury or sickness for which Medicare-approved a Home Care Treatment Plan:			
--- Benefit for each visit	$0	Actual charges to $40 a visit	Balance
--- Number of visits covered (must be received within 8 weeks of last Medicare-approved visit)	$0	Up to the number of Medicare-approved visits, not to exceed seven each week	
--- Calendar year maximum	$0	$1,600	
OTHER BENEFITS			
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States:			
First $250 each calendar year	$0	$0	$250
Remainder of charges [*]	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50% - $1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All costs

PLAN J

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but ~~[$764]~~ ***$812***	~~[$764]~~ ***$812*** (Part A Deductible)	$0
61st thru 90th day	All but ~~[$191]~~ ***$203*** a day	~~[$191]~~ ***$203*** a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but ~~[$382]~~ ***$406*** a day	~~[$382]~~ ***$406*** a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~[$95.50]~~ ***$101.50*** a day	Up to ~~[$95.50]~~ ***$101.50*** a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN J

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

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

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

PLAN J
MEDICARE (PARTS A & B) - (CONTINUED)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - (cont d)			
AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare-approved a Home Care Treatment Plan:			
--- Benefit for each visit	$0	Actual charges to $40 a visit	Balance
---Number of visits covered (must be received within 8 weeks of last Medicare-approved visit)	$0	Up to the number of Medicare-approved visits, not to exceed seven each week	
--- Calendar year maximum	$0	$1,600	
OTHER BENEFITS			
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States:			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
EXTENDED OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $6,000 each calendar year	$0	50% - $3,000 calendar year maximum benefit	50%
Over $6,000 each calendar year	$0	$0	All costs

PLAN J

OTHER BENEFITS - *(*CONTINUED*)*

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

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

HIGH DEDUCTIBLE BENEFIT PLAN J

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

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

** High Deductible Benefit Plan J offers benefits similar to the benefits offered by the Standardized Benefit Plan J except that the high deductible benefit plan requires the insured to pay a higher annual deductible. For ~~[the calendar years of 1998 and 1999]~~ ***calendar year 2001***, the High Deductible Benefit Plan J requires the insured to pay an annual deductible in the amount of ~~[$1,500]~~ ***$1,580***, and thereafter the plan requires the insured to pay an annual deductible that is adjusted by the Commissioner in the manner set forth in subsection 2 of NAC 687B.311. Benefits for the High Deductible Benefit Plan J begin after the insured has paid the annual deductible for expenses that would ordinarily be paid by the plan, including, without limitation, the Medicare Part A deductible and the Medicare Part B deductible. The annual deductible must be paid in addition to the premium and in addition to any other deductibles relating to a specific benefit, including, without limitation, the deductible for prescription drugs and the deductible for emergency care received in a foreign country.

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~[$1,500]~~ ***$1,580*** DEDUCTIBLE** PLAN PAYS	IN ADDITION TO ~~[$1,500]~~ ***$1,580*** DEDUCTIBLE** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but ~~[$764]~~ ***$812***	~~[$764]~~ ***$812*** (Part A Deductible)	$0
61st thru 90th day	All but ~~[$191]~~ ***$203*** a day	~~[$191]~~ ***$203*** a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but ~~[$382]~~ ***$406*** a day	~~[$382]~~ ***$406*** a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~[$95.50]~~ ***$101.50*** a day	Up to ~~[$95.50]~~ ***$101.50*** a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

HIGH DEDUCTIBLE BENEFIT PLAN J

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

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

** High Deductible Benefit Plan J offers benefits similar to the benefits offered by the Standardized Benefit Plan J except that the high deductible benefit plan requires the insured to pay a higher annual deductible. For ~~[the calendar years of 1998 and 1999]~~ ***calendar year 2001***, the High Deductible Benefit Plan J requires the insured to pay an annual deductible in the amount of ~~[$1,500]~~ ***$1,580***, and thereafter the plan requires the insured to pay an annual deductible that is adjusted by the Commissioner in the manner set forth in subsection 2 of NAC 687B.311. Benefits for the High Deductible Benefit Plan J begin after the insured has paid the annual deductible for expenses that would ordinarily be paid by the plan, including, without limitation, the Medicare Part A deductible and the Medicare Part B deductible. The annual deductible must be paid in addition to the premium and in addition to any other deductibles relating to a specific benefit, including, without limitation, the deductible for prescription drugs and the deductible for emergency care received in a foreign country.

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~[$1,500]~~ ***$1,580*** DEDUCTIBLE** PLAN PAYS	IN ADDITION TO ~~[$1,500]~~ $1,580 DEDUCTIBLE** YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First $100 of Medicare-approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Part B excess charges (above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare-approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
	PARTS A & B		
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
---Medically necessary skilled care services and medical supplies	100%	$0	$0
---Durable medical equipment: First $100 of Medicare-approved amounts*	$0	$100 (Part B Deductible)	$0

Remainder of Medicare-approved amounts	80%	20%	$0

HIGH DEDUCTIBLE BENEFIT PLAN J
MEDICARE (PARTS A & B) - *(*CONTINUED*)*

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~[$1,500]~~ ***$1,580*** DEDUCTIBLE** PLAN PAYS	IN ADDITION TO ~~[$1,500]~~ ***$1,580*** DEDUCTIBLE** YOU PAY
HOME HEALTH CARE - (cont d)			
AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare-approved a Home Care Treatment Plan:			
--- Benefit for each visit	$0	Actual charges to $40 a visit	Balance
---Number of visits covered (must be received within 8 weeks of last Medicare-approved visit)	$0	Up to the number of Medicare-approved visits, not to exceed seven each week	
--- Calendar year maximum	$0	$1,600	
OTHER BENEFITS			
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States:			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
EXTENDED OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $6,000 each calendar year	$0	50% - $3,000 calendar year maximum benefit	50%
Over $6,000 each calendar year	$0	$0	All costs

HIGH DEDUCTIBLE BENEFIT PLAN J

OTHER BENEFITS - *(*CONTINUED*)*

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

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