ADOPTED REGULATION OF

THE COMMISSIONER OF INSURANCE

LCB File No. R049-09

Effective October 27, 2009

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

AUTHORITY: §§1-30, NRS 679B.130 and 687B.430.

A REGULATION relating to insurance; creating new definitions related to standardized benefit plans; providing requirements for various policies to supplement Medicare or certificates; providing standards for various policies to supplement Medicare or certificates with an effective date for coverage on or after June 1, 2010; revising various existing standardized benefit plans; creating various new standardized benefit plans; providing requirements for issuers of various policies to supplement Medicare or certificates regarding genetic information; providing various requirements related to the reinstatement, offer and exchange of plans related to policies to supplement Medicare or certificates; and providing other matters properly relating thereto.

Section 1. Chapter 687B of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 7, inclusive, of this regulation.

Sec. 2. ***"1990 standardized benefit plan to supplement Medicare" or "1990 standardized benefit plan" means a policy to supplement Medicare issued on or after January 1, 1992, and with an effective date for coverage before June 1, 2010, and includes policies to supplement Medicare and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured.***

Sec. 3. ***"2010 standardized benefit plan to supplement Medicare" or "2010 standardized benefit plan" means a policy to supplement Medicare issued with an effective date for coverage on or after June 1, 2010.***

Sec. 4. *1. On or after June 1, 2010, no policy or certificate may be advertised, solicited, delivered or issued for delivery in this State as a policy to supplement Medicare or a certificate unless it complies with the standards provided for in sections 5 and 6 of this regulation.*

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

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

Sec. 5. *1. In addition to the standards set forth in section 6 of this regulation, the standards provided for in this section are:*

(a) Applicable to all policies to supplement Medicare or certificates delivered or issued for delivery in this State with an effective date for coverage on or after June 1, 2010; and

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

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

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

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

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

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

(b) A policy to supplement Medicare or a certificate must provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment or coinsurance amounts. Premiums may be modified to correspond with such changes.

(c) No policy to supplement Medicare or certificate may provide for the termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premiums.

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

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

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

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

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

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

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

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

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

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

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

(i) A policy to supplement Medicare or a certificate must provide that benefits and premiums under the policy or certificate must be suspended at the request of the policyholder or certificate holder for the period, not to exceed 24 months, during which the policyholder or certificate holder has applied for and is determined to be eligible for medical assistance under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 et seq., if the policyholder or certificate holder notifies the issuer of the policy or certificate within 90 days after the date the person becomes eligible for such assistance. If benefits or premiums are suspended and the policyholder or certificate holder loses eligibility for such medical assistance, the policy or certificate must be automatically reinstated effective as of the date eligibility is terminated if

the policyholder or certificate holder provides notice of loss of eligibility to the insurer within 90 days after the date of loss and pays the premium attributable to the period of eligibility.

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

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

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

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

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

3. On or after June 1, 2010, every issuer shall make available a policy or certificate which includes a basic core package of benefits to each prospective insured, but an issuer may make available to prospective insureds any of the other benefit plans to supplement Medicare in

addition to, but not in lieu of, the basic core package. The basic core package of benefits must consist of:

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

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

(c) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days, and the provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

(d) Coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations.

(e) Coverage for the coinsurance amount, or, in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

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

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

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

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

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

(d) Coverage for 100 percent of the Medicare Part B deductible amount per calendar year regardless of hospital confinement;

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

(f) Coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this paragraph, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

Sec. 6. *1. In addition to the standards set forth in section 5 of this regulation, the standards provided for in this section are:*

(a) Applicable to all policies to supplement Medicare or certificates delivered or issued for delivery in this State with an effective date for coverage on or after June 1, 2010; and

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

2. On or after June 1, 2010, an issuer shall make available to each prospective policyholder or certificate holder a policy form or certificate form containing only the basic core benefits, as set forth in subsection 3 of section 5 of this regulation.

3. On or after June 1, 2010, if an issuer makes available any of the additional benefits set forth in subsection 4 of section 5 of this regulation, or offers Standardized Benefit Plan K or L as described in paragraphs (h) and (i) of subsection 7, the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic core benefits as described in subsection 2, a policy form or certificate form containing either Standardized Benefit Plan C as described in paragraph (c) of subsection 7 or Standardized Benefit Plan F as described in paragraph (e) of subsection 7.

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

5. On or after June 1, 2010, a benefit plan must be uniform in structure, language, designation and format to the standardized benefit plans listed in this section and must conform to the definition in section 3 of this regulation. Each benefit must be structured in accordance with the format provided in subsections 3 and 4 of section 5 of this regulation or,

in the case of Standardized Benefit Plan K or L, in paragraphs (h) and (i) of subsection 7, and list the benefits in the order shown in the applicable requirements.

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

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

(a) A 2010 standardized benefit plan to supplement Medicare which is designated as Standardized Benefit Plan A must include only the basic core benefits as defined in subsection 3 of section 5 of this regulation.

(b) A 2010 standardized benefit plan to supplement Medicare which is designated as Standardized Benefit Plan B must include only the basic core benefits as defined in subsection 3 of section 5 of this regulation, plus 100 percent of the Medicare Part A deductible as defined in paragraph (a) of subsection 4 of section 5 of this regulation.

(c) A 2010 standardized benefit plan to supplement Medicare which is designated as Standardized Benefit Plan C must include only the basic core benefits as defined in subsection 3 of section 5 of this regulation, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in paragraphs (a), (c), (d) and (f) of subsection 4 of section 5 of this regulation, respectively.

(d) A 2010 standardized benefit plan to supplement Medicare which is designated as Standardized Benefit Plan D must include only the basic core benefits as defined in subsection 3 of section 5 of this regulation, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs (a), (c) and (f) of subsection 4 of section 5 of this regulation, respectively.

(e) A 2010 standardized benefit plan to supplement Medicare which is designated as Standardized Benefit Plan F must include only the basic core benefits as defined in subsection 3 of section 5 of this regulation, plus 100 percent of the Medicare Part A deductible, the skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (a), (c), (d), (e) and (f) of subsection 4 of section 5 of this regulation, respectively.

(f) A 2010 standardized benefit plan to supplement Medicare which is designated as High Deductible Benefit Plan F:

(1) Must include only 100 percent of covered expenses following the payment of the annual deductible set forth in subparagraph (2) and the basic core benefits as defined in subsection 3 of section 5 of this regulation, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (a), (c), (d), (e) and (f) of subsection 4 of section 5 of this regulation, respectively; and

(2) Has an annual deductible that:

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

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

(III) Has a base which must be $1,500 and must be adjusted annually from 1999 by the Secretary of the United States Department of Health and Human Services to reflect the

change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

(g) A 2010 standardized benefit plan to supplement Medicare which is designated as Standardized Benefit Plan G must include only the basic core benefits as defined in subsection 3 of section 5 of this regulation, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (a), (c), (e) and (f) of subsection 4 of section 5 of this regulation, respectively.

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

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

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

(3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days, and the provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(4) Coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph (10);

(5) Coverage for 50 percent of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subparagraph (10);

(6) Coverage for 50 percent of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph (10);

(7) Coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first 3 pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations, until the out-of-pocket limitation is met as described in subparagraph (10);

(8) Except for coverage provided in subparagraph (9), coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in subparagraph (10);

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

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

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

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

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

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

(j) A 2010 standardized benefit plan to supplement Medicare which is designated as Standardized Benefit Plan M must include only the basic core benefits as defined in subsection 3 of section 5 of this regulation, plus 50 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs (b), (c) and (f) of subsection 4 of section 5 of this regulation, respectively.

(k) A 2010 standardized benefit plan to supplement Medicare which is designated as Standardized Benefit Plan N must include only the basic core benefits as defined in subsection 3 of section 5 of this regulation, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care and medically necessary emergency care in a foreign country as defined in paragraphs (a), (c) and (f) of subsection 4 of section 5 of this regulation, respectively, with coinsurance or copayments in the following amounts:

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

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

8. On or after June 1, 2010, an issuer may, with the prior approval of the Commissioner, offer a policy to supplement Medicare or a certificate with new or innovative benefits in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards, and:

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

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

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

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

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

Sec. 7. *1. An issuer of a policy to supplement Medicare or a certificate:*

(a) Shall not deny or condition the issuance or effectiveness of the policy or certificate, including, without limitation, the imposition of any exclusion of benefits under the policy based on a preexisting condition, on the basis of the genetic information of a person; and

(b) Shall not discriminate in the pricing of the policy or certificate, including, without limitation, the adjustment of the premium rates, of a person on the basis of the genetic information of the person.

2. Nothing in subsection 1 shall be construed to limit the ability of an issuer of a policy to supplement Medicare or a certificate, to the extent otherwise permitted by law, from:

(a) Denying or conditioning the issuance or effectiveness of a policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or

(b) Increasing the premium for any policy issued to a person based on the manifestation of a disease or disorder of a person who is covered under the policy. The manifestation of a disease or disorder in one person cannot also be used as genetic information about other group members and to further increase the premium for the group.

3. An issuer of a policy to supplement Medicare or a certificate shall not request or require a person or a family member of the person to undergo a genetic test.

4. The provisions in subsection 3 must not be construed to preclude an issuer of a policy to supplement Medicare or a certificate from obtaining and using the results of a genetic test in making a determination regarding payment as defined for the purposes of applying the regulations promulgated under Part C of Title XI and section 264 of the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. §§ 1320d et seq., and note to 42 U.S.C. § 1320d-2, as may be revised from time to time, and consistent with the provisions of subsection 1.

5. For the purposes of carrying out subsection 4, an issuer of a policy to supplement Medicare or a certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

6. Notwithstanding the provisions of subsection 3, an issuer of a policy to supplement Medicare or a certificate may request, but not require, that a person or a family member of the person undergo a genetic test if:

(a) The request is made pursuant to research that complies with 45 C.F.R. § 46.101 et seq., or equivalent federal regulations, and any applicable state or local law or regulations for the protection of human subjects in research;

(b) The issuer clearly indicates to each person, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that:

(1) Compliance with the request is voluntary; and

(2) Noncompliance will have no effect on enrollment status or premium or contribution amounts;

(c) Any genetic information collected or acquired under this subsection is not used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal or replacement of a policy or certificate;

(d) The issuer notifies the Secretary of the United States Department of Health and Human Services in writing that the issuer is conducting activities pursuant to the exception provided for under this subsection, including a description of the activities conducted; and

(e) The issuer complies with such other conditions as the Secretary of the United States Department of Health and Human Services may, by regulation, require for activities conducted under this subsection.

7. An issuer of a policy to supplement Medicare or a certificate shall not request, require or purchase genetic information for underwriting purposes.

8. An issuer of a policy to supplement Medicare or a certificate shall not request, require, or purchase genetic information with respect to any person before the person's enrollment under the policy in connection with such enrollment.

9. If an issuer of a policy to supplement Medicare or a certificate obtains genetic information incidental to the requesting, requiring or purchasing of other information concerning any person, such request, requirement or purchase must not be considered a violation of the provisions of subsection 8 if such request, requirement or purchase is not in violation of the provisions of subsection 7.

10. As used in this section:

(a) "Family member" means, with respect to a person, any other person who is a first degree, second degree, third degree or fourth degree relative of the person.

(b) "Genetic information" means, with respect to any person, information about a genetic test of the person, the genetic tests of family members of the person, and the manifestation of a disease or disorder in family members of the person, and any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by the person or any family member of the person. Any reference to "genetic information" concerning a person or family member of the person who is a pregnant woman includes, without limitation, genetic information of any fetus carried by such pregnant woman, or, with respect to the person or family member utilizing reproductive technology, includes, without limitation, genetic information of any embryo legally held by the person or family member. The term does not include information about the sex or age of a person.

(c) "Genetic services" means a genetic test, genetic education and genetic counseling, including obtaining, interpreting or assessing genetic information.

(d) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites that detects genotypes, mutations or chromosomal changes. The term does not include:

(1) An analysis of proteins or metabolites that does not detect genotypes, mutations or chromosomal changes; or

(2) An analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the applicable field of medicine.

(e) "Issuer of a policy to supplement Medicare or a certificate" includes third-party administrator, or other person acting for or on behalf of such issuer.

(f) "Underwriting purposes" means:

(1) Rules for, or determination of, eligibility, including, without limitation, enrollment and continued eligibility for benefits under the policy;

(2) The computation of premium or contribution amounts under the policy;

(3) The application of any preexisting condition exclusion under the policy; and

(4) Other activities related to the creation, renewal or replacement of a contract of health insurance or health benefits.

Sec. 8. NAC 687B.200 is hereby amended to read as follows:

687B.200 As used in NAC 687B.200 to 687B.330, inclusive, ***and sections 2 to 7, inclusive, of this regulation,*** unless the context otherwise requires, the words and terms defined in NAC

687B.201 to 687B.2045, inclusive, ***and sections 2 and 3 of this regulation*** have the meanings ascribed to them in those sections.

Sec. 9. NAC 687B.2045 is hereby amended to read as follows:

687B.2045 "Standardized benefit plan" means a benefit plan to supplement Medicare that is designated as Standardized Benefit Plan A through ~~[L,]~~ ***N,*** inclusive, or High Deductible Benefit Plan F or J, as set forth in NAC 687B.300 to 687B.321, inclusive ~~[.]~~ ***, and sections 5 and 6 of this regulation.***

Sec. 10. NAC 687B.220 is hereby amended to read as follows:

687B.220 1. Except as otherwise provided in paragraphs (a) and (b) of subsection 2 of NAC 687B.226 and paragraphs (a) and (b) of subsection 2 of NAC 687B.227, ***and subparagraphs (1) and (2) of paragraph (a) of subsection 2 of section 5 of this regulation,*** a policy or certificate may not be advertised, solicited or issued for delivery in this State as a policy to supplement Medicare if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

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

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

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

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

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

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

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

Sec. 11. NAC 687B.225 is hereby amended as follows:

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

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

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

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

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

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

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

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

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

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

6. A policy to supplement Medicare that is subject to the minimum standards adopted pursuant to the Medicare Catastrophic Coverage Act of 1988 ***, Public Law 100-360, 102 Stat. 683, July 1, 1988,*** must provide at least the following benefits:

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

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

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

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

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

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

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

7. For the purposes of this section:

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

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

Sec. 12. NAC 687B.226 is hereby amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

(b) An individual policy to supplement Medicare that provides only those benefits as are ~~[required by NAC 687B.290.]~~ ***set forth in subsection 3 of section 5 of this regulation.***

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

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

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

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

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

10. If a policy to supplement Medicare eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and

Modernization Act of 2003, Public Law 108-173, 117 Stat. 2066, December 8, 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this section.

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

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

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

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

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

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

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

coverage must include coverage for Medicare eligible expenses for drugs used by an outpatient for immune suppressive therapy.

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

Sec. 13. NAC 687B.227 is hereby amended to read as follows:

687B.227 1. A policy or certificate must not be advertised, solicited, originally delivered or issued for delivery, or renewed in this State as a policy or certificate to supplement Medicare on or after July 30, 1992, ***and with an effective date for coverage before June 1, 2010,*** if it fails to comply with the requirements set forth in this section.

2. A policy to supplement Medicare or a certificate originally delivered or issued for delivery, or renewed, in this State on or after July 30, 1992, ***and with an effective date for coverage before June 1, 2010,*** 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.]~~ ***, copayment or coinsurance amounts.*** Premiums may be modified to correspond with such changes.

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

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

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

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

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

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

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

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

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, if the suspended policy to supplement***

Medicare provided coverage for outpatient prescription drugs, reinstatement of the policy for Medicare Part D enrollees must be without coverage for outpatient prescription drugs and must otherwise provide substantially equivalent coverage 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.

11. If an issuer makes a written offer to the Medicare Supplement policyholder or certificate holder of one or more of its plans to exchange, during a specified period, from his or her 1990 standardized benefit plan, as described in NAC 687B.295, to a 2010 standardized benefit plan, as described in section 6 of this regulation, the offer and subsequent exchange must comply with the following requirements:

(a) The issuer need not provide justification to the Commissioner if the insured replaces a 1990 standardized benefit plan or certificate with an issue age rated 2010 standardized benefit plan or certificate at the insured's original issue age and duration;

(b) If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of such offer, the rate charged to the insured for the new exchanged policy must recognize the policy reserve buildup, due to the prefunding inherent in the use of an issue age rate basis, for the benefit of the insured;

(c) The method proposed to be used by the issuer must be filed with the Commissioner pursuant to NAC 687B.229;

(d) The rating class of the new policy or certificate must be the class closest to the class of the replaced coverage;

(e) The issuer may not apply new limitations on preexisting conditions or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 standardized benefit plan or certificate of the insured, but may apply limitations of not more than 6 months on preexisting conditions to any added benefits contained in the new 2010 standardized benefit plan or certificate not contained in the exchanged policy; and

(f) The new policy or certificate must be offered to all policyholders or certificate holders within a given plan, except where the offer or issue would be in violation of state or federal law.

Sec. 14. NAC 687B.250 is hereby amended to read as follows:

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

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

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

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

(a) A cover page;

(b) Information regarding premiums;

(c) Disclosure pages; and

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

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

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

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

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

~~[(COMPANY NAME)~~
~~Outline of Medicare Supplement Coverage – Cover Page:~~
~~Benefit Plan(s)___ insert letter(s) of plan(s) being offered~~

~~This chart shows the benefits included in each of the Standard Medicare Supplement Plans.~~
~~Every company must make available Plan "A."~~

~~See Outlines of Coverage sections for details about ALL plans.~~

~~Basic Benefits for Plans A-J, inclusive:~~
~~Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.~~
~~Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services.~~
~~Blood: First 3 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 Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	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
				Preventive Care NOT covered by Medicare						Preventive Care NOT covered by Medicare	Preventive Care NOT covered by Medicare

* The High Deductible Benefit Plans F and J offer benefits similar to the benefits offered by the Standardized Benefit Plans F and J except that the high deductible benefit plans require a higher deductible. The annual deductibles for the High Deductible Benefit Plans F and J are subject to change. For the current deductibles, please consult the most current version of the Guide to Health Insurance for People with Medicare which must be provided by an issuer to an applicant pursuant to NAC 687B.240. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. The annual deductibles for the High Deductible Benefit Plans F and J may be adjusted annually by the Secretary of the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for All Urban Consumers published by the United States Department of Labor for the calendar year ending on July 31 of the immediately preceding year, and rounded to the nearest multiple of $10. Benefits for the High Deductible Benefit Plans F and J begin after the insured has paid the annual deductible for expenses that would ordinarily be paid by the plans, including, without limitation, the Medicare Part A deductible and the Medicare Part B deductible. The annual deductible must be paid in addition to the premium and in addition to any other deductibles relating to a specific benefit, including, without limitation, the deductible for prescription drugs, if applicable, and the deductible for emergency care received in a foreign country.

(COMPANY NAME)
Outline of Medicare Supplement Coverage-Cover Page 2

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

	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 50% Hospice cost sharing 50% of Medicare-eligible expenses for the first 3 pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 75% Hospice cost sharing 75% of Medicare-eligible expenses for the first 3 pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At Home Recovery		

	K**	L**
Preventive Care NOT covered by Medicare		

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

The out-of-pocket annual limit will increase each year for inflation.
See Outlines of Coverage for details and exceptions.]

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

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

Plans E, H, I and J are no longer available for sale. [This sentence must not appear after June 1, 2011.]

Basic Benefits:

Hospitalization - Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses - Part B coinsurance (generally 20 percent of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.

Blood - First three pints of blood each year.

Hospice - Part A coinsurance.

A	*B*	*C*	*D*	*F*	*F**	*G*		*K*	*L*	*M*	*N*
Basic, including 100% Part B coinsurance	*Basic, including 100% Part B coinsurance*	*Basic, including 100% Part B coinsurance*	*Basic, including 100% Part B coinsurance*	*Basic, including 100% Part B coinsurance*		*Basic, including 100% Part B coinsurance*		*Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%*	*Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%*	*Basic, including 100% Part B coinsurance*	*Basic, including 100% Part B coinsurance, except up to *** copayment for office visit, and up to *** copayment for ER*

		Skilled Nursing Facility Coinsurance	*Skilled Nursing Facility Coinsurance*	*Skilled Nursing Facility Coinsurance*	*Skilled Nursing Facility Coinsurance*		*50% Skilled Nursing Facility Coinsurance*	*75% Skilled Nursing Facility Coinsurance*	*Skilled Nursing Facility Coinsurance*	*Skilled Nursing Facility Coinsurance*
	Part A Deductible	*Part A Deductible*	*Part A Deductible*	*Part A Deductible*	*Part A Deductible*		*50% Part A Deductible*	*75% Part A Deductible*	*50% Part A Deductible*	*Part A Deductible*
		Part B Deductible		*Part B Deductible*						
				Part B Excess (100%)	*Part B Excess (100%)*					
		Foreign Travel Emergency	*Foreign Travel Emergency*	*Foreign Travel Emergency*	*Foreign Travel Emergency*				*Foreign Travel Emergency*	*Foreign Travel Emergency*
							*Out-of-pocket limit**; paid at 100% after limit reached*	*Out-of-pocket limit**; paid at 100% after limit reached*		

** Plan F also has an option called a High Deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses exceed the deductible. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.*

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

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

PREMIUM INFORMATION (Boldface type)

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

DISCLOSURES (Boldface type)

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold with effective dates on or after June 1, 2010. Policies sold with effective dates before June 1, 2010, have different benefits and

premiums. Plans E, H, I and J are no longer available for sale. (This paragraph must not appear after June 1, 2011.)

READ YOUR POLICY VERY CAREFULLY

(Boldface type)

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

RIGHT TO RETURN POLICY (Boldface type)

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

POLICY REPLACEMENT (Boldface type)

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

NOTICE (Boldface type)

This policy may not cover all of your medical costs.

(For agents)

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

(For direct response)

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT

(Boldface type)

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

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

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

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

PLAN A

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

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

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

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

~~**** You pay all costs that Medicare does not pay.]~~ ***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.***

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE ~~[Available as long as your doctor certifies you are terminally ill and you elect to receive these services]~~ ***You must meet Medicare's requirements, including a doctor's certification of terminal illness***	All but very limited ***copayment/***coinsurance for outpatient drugs and inpatient respite care	~~[$0]~~ ***Medicare copayment/coinsurance***	~~[Balance]~~ ***$0***

PLAN A

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

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

~~[** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.]~~

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: ***First portion of*** Medicare-approved amounts ~~[equal to the Part B Deductible]~~ * Remainder of Medicare-approved amounts	 $0 Generally 80%	 $0 Generally 20%	 ***(*** Part B Deductible ***)*** ~~[**]~~ $0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD First 3 pints ***Next portion of*** Medicare-approved amounts ~~[equal to the part B deductible]~~ * Remainder of Medicare-approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 ***(*** Part B Deductible ***)*** ~~[**]~~ $0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN A

PARTS A & B

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

~~[** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.]~~

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

PLAN B

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

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

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

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

~~**** You pay all costs that Medicare does not pay.]~~ ***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.***

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

PLAN B

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

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

~~[** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.]~~

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First portion of Medicare-approved amounts ~~[equal to the Part B Deductible]~~ *	$0	$0	***(*** Part B Deductible ***)*** ~~[**]~~
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next portion of Medicare-approved amounts ~~[equal to the Part B Deductible]~~ *	$0	$0	***(*** Part B Deductible ***)*** ~~[**]~~
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN B

PARTS A & B

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

~~[** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.]~~

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

PLAN C

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

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

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

*** ~~[The plan pays all costs that Medicare does not pay.]~~ ***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.***

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

PLAN C

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

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

~~[** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.]~~

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: ***First portion of*** Medicare-approved amounts ~~[equal to the Part B Deductible]~~ * Remainder of Medicare-approved amounts	 $0 Generally 80%	 ***(*** Part B Deductible ***)*** ~~[**]~~ Generally 20%	 $0 $0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD First 3 pints ***Next portion of*** Medicare-approved amounts ~~[equal to the Part B Deductible]~~ * Remainder of Medicare-approved amounts	$0 $0 80%	All costs ***(*** Part B Deductible ***)*** ~~[**]~~ 20%	$0 $0 $0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN C

PARTS A & B

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

~~[** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.]~~

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

PLAN C

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

PLAN D

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

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

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

*** ~~[The plan pays all costs that Medicare does not pay.]~~ ***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.***

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	 All approved amounts ***All but*** ** ***a day*** $0	 $0 ~~[***]~~ ***Up to** a day* $0	 $0 $0 All costs
BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE ~~[Available as long as your doctor certifies you are terminally ill and you elect to receive these services]~~ ***You must meet Medicare's requirements, including a doctor's certification of terminal illness***	All but very limited ***copayment/***coinsurance for outpatient drugs and inpatient respite care	~~[$0]~~ ***Medicare copayment/coinsurance***	~~[Balance]~~ ***$0***

PLAN D

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

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

~~[** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.]~~

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: ***First portion of*** Medicare-approved amounts ~~[equal to the Part B Deductible]~~ * Remainder of Medicare-approved amounts	 $0 Generally 80%	 $0 Generally 20%	 ***(*** Part B Deductible ***)*** ~~[**]~~ $0
Part B Excess Charges (Above Medicare-approved amounts)	 $0	 $0	 All costs
BLOOD First 3 pints ***Next portion of*** Medicare-approved amounts ~~[equal to the Part B Deductible]~~ * Remainder of Medicare-approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 ***(*** Part B Deductible ***)*** ~~[**]~~ $0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN D

PARTS A & B

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

~~[** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.]~~

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

PLAN D

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

~~[PLAN E~~

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

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

~~** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the Guide to Health Insurance for People with Medicare, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.~~

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	 All approved amounts ** $0	 $0 *** $0	 $0 $0 All costs
BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN E

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

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

** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the Guide to Health Insurance for People with Medicare, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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: Medicare-approved amounts equal to the Part B Deductible* Remainder of Medicare-approved amounts	 $0 Generally 80%	 $0 Generally 20%	 Part B Deductible ** $0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD First 3 pints Medicare-approved amounts equal to the Part B Deductible* Remainder of Medicare-approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 Part B Deductible ** $0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the Guide to Health Insurance for People with Medicare, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

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

PLAN E

OTHER BENEFITS - NOT COVERED BY MEDICARE

* Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the Guide to Health Insurance for People with Medicare, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

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

PLAN F

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

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

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

*** [The plan pays all costs that Medicare does not pay.] ***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.***

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	 All approved amounts ***All but*** ** ***a day*** $0	 $0 ~~[***]~~ ***Up to** a day* $0	 $0 $0 All costs
BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE ~~[Available as long as your doctor certifies you are terminally ill and you elect to receive these services]~~ ***You must meet Medicare's requirements, including a doctor's certification of terminal illness***	All but very limited ***copayment/***coinsurance for outpatient drugs and inpatient respite care	~~[$0]~~ ***Medicare copayment/coinsurance***	~~[Balance]~~ ***$0***

PLAN F

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

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

~~[** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.]~~

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: ***First portion of*** Medicare-approved amounts ~~[equal to the Part B Deductible]~~ * Remainder of Medicare-approved amounts	 $0 Generally 80%	 ***(*** Part B Deductible ***)*** ~~[**]~~ Generally 20%	 $0 $0
Part B Excess Charges (Above Medicare-approved amounts)	$0	100%	$0
BLOOD First 3 pints ***Next portion of*** Medicare-approved amounts ~~[equal to the Part B Deductible]~~ * Remainder of Medicare-approved amounts	 $0 $0 80%	 All costs ***(*** Part B Deductible ***)*** ~~[**]~~ 20%	 $0 $0 $0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN F

PARTS A & B

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

[** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.]

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

PLAN F

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

HIGH DEDUCTIBLE BENEFIT PLAN F

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

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

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

*** [The plan pays the costs that Medicare does not pay after you pay the deductible.] ***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.***

**** The High Deductible Benefit Plan F [offers] pays ***the same*** benefits [similar to the benefits offered by] ***as*** the Standardized Benefit Plan F [except that the high deductible benefit plan requires the insured to pay a higher annual] ***after one has paid a calendar year*** deductible. The annual deductible for the High Deductible Benefit Plan F is subject to change. For the current deductible, please consult the most current version of the *Guide to Health Insurance for People with Medicare* **,** which must be provided by an issuer to an applicant pursuant to NAC 687B.240. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. [The annual deductible for the High Deductible Benefit Plan F may be adjusted annually by the Secretary of the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for All Urban Consumers published by the United States Department of Labor for the calendar year ending on July 31 of the immediately preceding year, and rounded to the nearest multiple of $10.] Benefits [for] ***from*** the High Deductible Benefit Plan F ***will not*** begin [after the insured has paid the annual deductible for] ***until out-of-pocket*** expenses ***are equal to the calendar year deductible. Out-of-pocket expenses for this deductible are expenses*** that would ordinarily be paid by the [plan, including, without limitation,] ***policy. This includes, without limitation,*** the Medicare ***deductibles for*** 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] ***, but does not include the plan's separate foreign travel*** emergency [care received in a foreign country.] ***deductible.***

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

HIGH DEDUCTIBLE BENEFIT PLAN F

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

* Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year. The Part B Deductible will be applied toward the annual deductible for the calendar year set forth in NAC 687B.311.

~~[** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.]~~

~~[***]~~ ** The High Deductible Benefit Plan F ~~[offers]~~ pays ***the same*** benefits ~~[similar to the benefits offered by]~~ ***as*** the Standardized Benefit Plan F ~~[except that the high deductible benefit plan requires the insured to pay a higher annual]~~ ***after one has paid a calendar year*** deductible. The annual deductible for the High Deductible Benefit Plan F is subject to change. For the current deductible, please consult the most current version of the *Guide to Health Insurance for People with Medicare* , which must be provided by an issuer to an applicant pursuant to NAC 687B.240. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. ~~[The annual deductible for the High Deductible Benefit Plan F may be adjusted annually by the Secretary of the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for All Urban Consumers published by the United States Department of Labor for the calendar year ending on July 31 of the immediately preceding year, and rounded to the nearest multiple of $10.]~~ Benefits ~~[for]~~ ***from*** the High Deductible Benefit Plan F ***will not*** begin ~~[after the insured has paid the annual deductible for]~~ ***until out-of-pocket*** expenses ***are equal to the calendar year deductible. Out-of-pocket expenses for this deductible are expenses*** that would ordinarily be paid by the ~~[plan, including, without limitation,]~~ ***policy. This includes, without limitation,*** the Medicare ***deductibles for*** 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]~~ ***, but does not include the plan's separate foreign travel*** emergency ~~[care received in a foreign country.]~~ ***deductible.***

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

SERVICES	MEDICARE PAYS	AFTER YOU PAY THE DEDUCTIBLE , PLAN PAYS ~~[***]~~ **	IN ADDITION TO THE DEDUCTIBLE , YOU PAY ~~[***]~~ **
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First portion of Medicare-approved amounts ~~[equal to the Part B Deductible]~~ *	$0	***(*** Part B Deductible ***)*** ~~[**]~~	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next portion of Medicare-approved amounts ~~[equal to the Part B Deductible]~~ *	$0	***(*** Part B Deductible ***)*** ~~[**]~~	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE BENEFIT PLAN F

MEDICARE (PARTS A & B)

* Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year. The Part B Deductible will be applied toward the annual deductible for the calendar year set forth in NAC 687B.311.

~~[** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.]~~

~~[***]~~ ** The High Deductible Benefit Plan F ~~[offers]~~ pays ***the same*** benefits ~~[similar to the benefits offered by]~~ ***as*** the Standardized Benefit Plan F ~~[except that the high deductible benefit plan requires the insured to pay a higher annual]~~ ***after one has paid a calendar year*** deductible. The annual deductible for the High Deductible Benefit Plan F is subject to change. For the current deductible, please consult the most current version of the *Guide to Health Insurance for People with Medicare* **,** which must be provided by an issuer to an applicant pursuant to NAC 687B.240. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. ~~[The annual deductible for the High Deductible Benefit Plan F may be adjusted annually by the Secretary of the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for All Urban Consumers published by the United States Department of Labor for the calendar year ending on July 31 of the immediately preceding year, and rounded to the nearest multiple of $10.]~~ Benefits ~~[for]~~ ***from*** the High Deductible Benefit Plan F ***will not*** begin ~~[after the insured has paid the annual deductible for]~~ ***until out-of-pocket*** expenses ***are equal to the calendar year deductible. Out-of-pocket expenses for this deductible are expenses*** that would ordinarily be paid by the ~~[plan, including, without limitation,]~~ ***policy. This includes, without limitation,*** the Medicare ***deductibles for*** 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]~~ ***, but does not include the plan's separate foreign travel*** emergency ~~[care received in a foreign country.]~~ ***deductible.***

SERVICES	MEDICARE PAYS	AFTER YOU PAY THE DEDUCTIBLE , PLAN PAYS ~~[***]~~ **	IN ADDITION TO THE DEDUCTIBLE , YOU PAY ~~[***]~~ **
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment:			
First portion of Medicare-approved amounts ~~[equal to the Part B Deductible]~~ *	$0	***(*** Part B Deductible ***)*** ~~[**]~~	$0
Remainder of Medicare-approved amounts	80%	20%	$0

HIGH DEDUCTIBLE BENEFIT PLAN F

OTHER BENEFITS - NOT COVERED BY MEDICARE

* The High Deductible Benefit Plan F ~~[offers]~~ pays ***the same*** benefits ~~[similar to the benefits offered by]~~ ***as*** the Standardized Benefit Plan F ~~[except that the high deductible benefit plan requires the insured to pay a higher annual]~~ ***after one has paid a calendar year*** deductible. The annual deductible for the High Deductible Benefit Plan F is subject to change. For the current deductible, please consult the most current version of the *Guide to Health Insurance for People with Medicare* **,** which must be provided by an issuer to an applicant pursuant to NAC 687B.240. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. ~~[The annual deductible for the High Deductible Benefit Plan F may be adjusted annually by the Secretary of the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for All Urban Consumers published by the United States Department of Labor for the calendar year ending on July 31 of the immediately preceding year, and rounded to the nearest multiple of $10.]~~ Benefits ~~[for]~~ ***from*** the High Deductible Benefit Plan F ***will not*** begin ~~[after the insured has paid the annual deductible for]~~ ***until out-of-pocket*** expenses ***are equal to the calendar year deductible. Out-of-pocket expenses for this deductible are expenses*** that would ordinarily be paid by the ~~[plan, including, without limitation,]~~ ***policy. This includes, without limitation,*** the Medicare ***deductibles for*** 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]~~ ***, but does not include the plan's separate foreign travel*** emergency ~~[care received in a foreign country.]~~ ***deductible.***

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

PLAN G

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

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

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

*** ~~[The plan pays the costs that Medicare does not pay.]~~ ***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.***

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	 All approved amounts ***All but*** ** ***a day*** $0	 $0 ~~[***]~~ ***Up to ** a day*** $0	 $0 $0 All costs
BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE ~~[Available as long as your doctor certifies you are terminally ill and you elect to receive these services]~~ ***You must meet Medicare's requirements, including a doctor's certification of terminal illness***	All but very limited ***copayment/***coinsurance for outpatient drugs and inpatient respite care	~~[$0]~~ ***Medicare copayment/coinsurance***	~~[Balance]~~ ***$0***

PLAN G

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

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

~~[** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.]~~

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: ***First portion of*** Medicare-approved amounts ~~[equal to the Part B Deductible]~~ * Remainder of Medicare-approved amounts	 $0 Generally 80%	 $0 Generally 20%	 ***(*** Part B Deductible ***)*** ~~[**]~~ $0
Part B Excess Charges (Above Medicare-approved amounts)	$0	~~[80%]~~ ***100%***	~~[20%]~~ ***$0***
BLOOD First 3 pints ***Next portion of*** Medicare-approved amounts ~~[equal to the Part B Deductible]~~ * Remainder of Medicare-approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 ***(*** Part B Deductible ***)*** ~~[**]~~ $0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN G

PARTS A & B

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

[** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.]

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

PLAN G

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

[PLAN H

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

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

** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the Guide to Health Insurance for People with Medicare, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

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

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

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

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

** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the Guide to Health Insurance for People with Medicare, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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: Medicare-approved amounts equal to the Part B Deductible* Remainder of Medicare-approved amounts	 $0 Generally 80%	 $0 Generally 20%	 Part B Deductible ** $0
Part B Excess Charges (Above Medicare-approved amounts)	 $0	 $0	 All costs
BLOOD First 3 pints Medicare-approved amounts equal to the Part B Deductible* Remainder of Medicare-approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 Part B Deductible ** $0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	 100%	 $0	 $0

PLAN H

PARTS A & B

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

** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the Guide to Health Insurance for People with Medicare, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

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

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

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

PLAN I

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

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

** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the Guide to Health Insurance for People with Medicare , which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

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

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

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

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

** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the Guide to Health Insurance for People with Medicare, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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: Medicare-approved amounts equal to the Part B Deductible* Remainder of Medicare-approved amounts	 $0 Generally 80%	 $0 Generally 20%	 Part B Deductible ** $0
Part B Excess Charges (Above Medicare-approved amounts)	$0	100%	$0
BLOOD First 3 pints Medicare-approved amounts equal to the Part B Deductible* Remainder of Medicare-approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 Part B Deductible ** $0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN I

PARTS A & B

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

** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the Guide to Health Insurance for People with Medicare, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

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

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

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

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

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

** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the Guide to Health Insurance for People with Medicare , which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	**	*** (Part A Deductible)	$0
61st thru 90th day	**	***	$0
91st day and after:			
While using 60 lifetime reserve days	**	***	$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	**	***	$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 a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the Guide to Health Insurance for People with Medicare, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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:			
Medicare-approved amounts equal to the Part B Deductible*	$0	Part B Deductible **	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0

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

PARTS A & B

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

** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the Guide to Health Insurance for People with Medicare, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

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

PLAN J

OTHER BENEFITS - NOT COVERED BY MEDICARE

* Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the Guide to Health Insurance for People with Medicare , which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

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

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

HIGH DEDUCTIBLE BENEFIT PLAN J

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

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

** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the Guide to Health Insurance for People with Medicare, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

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

**** The High Deductible Benefit Plan J offers benefits similar to the benefits offered by the Standardized Benefit Plan J except that the high deductible benefit plan requires the insured to pay a higher annual deductible. The annual deductible for the High Deductible Benefit Plan J is subject to change. For the current deductible, please consult the most current version of the Guide to Health Insurance for People with Medicare , which must be provided by an issuer to an applicant pursuant to NAC 687B.240. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. The annual deductible for the High Deductible Benefit Plan J may be adjusted annually by the Secretary of the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for All Urban Consumers published by the United States Department of Labor for the calendar year ending on July 31 of the immediately preceding year, and rounded to the nearest multiple of $10. Benefits for the High Deductible Benefit Plan J begin after the insured has paid the annual deductible for expenses that would ordinarily be paid by the plan, including, without limitation, the Medicare Part A deductible and the Medicare Part B deductible. The annual deductible must be paid in addition to the premium and in addition to any other deductibles relating to a specific benefit, including, without limitation, the deductible for prescription drugs and the deductible for emergency care received in a foreign country.

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

SERVICES	MEDICARE PAYS	AFTER YOU PAY THE DEDUCTIBLE PLAN PAYS****	IN ADDITION TO THE DEDUCTIBLE YOU PAY****
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: — First 20 days — 21st thru 100th day — 101st day and after	 All approved amounts ** $0	 $0 *** $0	 $0 $0 All costs
BLOOD — First 3 pints — Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

HIGH DEDUCTIBLE BENEFIT PLAN J

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

* Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year. The Part B Deductible will be applied toward the annual deductible for the calendar year set forth in NAC 687B.319.

** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the Guide to Health Insurance for People with Medicare, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

*** The High Deductible Benefit Plan J offers benefits similar to the benefits offered by the Standardized Benefit Plan J except that the high deductible benefit plan requires the insured to pay a higher deductible. The annual deductible for the High Deductible Benefit Plan J is subject to change. For the current deductible, please consult the most current version of the Guide to Health Insurance for People with Medicare , which must be provided by an issuer to an applicant pursuant to NAC 687B.240. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. The annual deductible for the High Deductible Benefit Plan J may be adjusted annually by the Secretary of the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for All Urban Consumers published by the United States Department of Labor for the calendar year ending on July 31 of the immediately preceding year, and rounded to the nearest multiple of $10. Benefits for the High Deductible Benefit Plan J begin after the insured has paid the annual deductible for expenses that would ordinarily be paid by the plan, including, without limitation, the Medicare Part A deductible and the Medicare Part B deductible. The annual deductible must be paid in addition to the premium and in addition to any other deductibles relating to a specific benefit, including, without limitation, the deductible for prescription drugs and the deductible for emergency care received in a foreign country.

SERVICES	MEDICARE PAYS	AFTER YOU PAY THE DEDUCTIBLE PLAN PAYS ***	IN ADDITION TO THE DEDUCTIBLE YOU PAY ***
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: — Medicare-approved amounts equal to the Part B Deductible* — Remainder of Medicare-approved amounts	 $0 Generally 80%	 Part B Deductible ** 20%	 $0 $0

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

HIGH DEDUCTIBLE BENEFIT PLAN J

MEDICARE (PARTS A & B)

* Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year. The Part B Deductible will be applied toward the annual deductible for the calendar year set forth in NAC 687B.319.

** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the Guide to Health Insurance for People with Medicare, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

*** The High Deductible Benefit Plan J offers benefits similar to the benefits offered by the Standardized Benefit Plan J except that the high deductible benefit plan requires the insured to pay a higher annual deductible. The annual deductible for the High Deductible Benefit Plan J is subject to change. For the current deductible, please consult the most current version of the Guide to Health Insurance for People with Medicare , which must be provided by an issuer to an applicant pursuant to NAC 687B.240. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. The annual deductible for the High Deductible Benefit Plan J may be adjusted annually by the Secretary of the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for All Urban Consumers published by the United States Department of Labor for the calendar year ending on July 31 of the immediately preceding year, and rounded to the nearest multiple of $10. Benefits for the High Deductible Benefit Plan J begin after the insured has paid the annual deductible for expenses that would ordinarily be paid by the plan, including, without limitation, the Medicare Part A deductible and the Medicare Part B deductible. The annual deductible must be paid in addition to the premium and in addition to any other deductibles relating to a specific benefit, including, without limitation, the deductible for prescription drugs and the deductible for emergency care received in a foreign country.

SERVICES	MEDICARE PAYS	AFTER YOU PAY THE DEDUCTIBLE PLAN PAYS ***	IN ADDITION TO THE DEDUCTIBLE YOU PAY ***
HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment: Medicare-approved amounts equal to the Part B Deductible* Remainder of Medicare-approved amounts	 100% $0 80%	 $0 Part B Deductible ** 20%	 $0 $0 $0

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

HIGH DEDUCTIBLE BENEFIT PLAN J

OTHER BENEFITS - NOT COVERED BY MEDICARE

* The High Deductible Benefit Plan J offers benefits similar to the benefits offered by the Standardized Benefit Plan J except that the high deductible benefit plan requires the insured to pay a higher annual deductible. The annual deductible for the High Deductible Benefit Plan J is subject to change. For the current deductible, please consult the most current version of the Guide to Health Insurance for People with Medicare , which must be provided by an issuer to an applicant pursuant to NAC 687B.240. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. The annual deductible for the High Deductible Benefit Plan J may be adjusted annually by the Secretary of the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for All Urban Consumers published by the United States Department of Labor for the calendar year ending on July 31 of the immediately preceding year, and rounded to the nearest multiple of $10. Benefits for the High Deductible Benefit Plan J begin after the insured has paid the annual deductible for expenses that would ordinarily be paid by the plan, including, without limitation, the Medicare Part A deductible and the Medicare Part B deductible. The annual deductible must be paid in addition to the premium and in addition to any other deductibles relating to a specific benefit, including, without limitation, the deductible for prescription drugs and the deductible for emergency care received in a foreign country.

** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the Guide to Health Insurance for People with Medicare , which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

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

SERVICES	MEDICARE PAYS	AFTER YOU PAY THE DEDUCTIBLE PLAN PAYS*	IN ADDITION TO THE DEDUCTIBLE YOU PAY*
FOREIGN TRAVEL - NOT COVERED BY MEDICARE** Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States: — First $250 each calendar year — Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum
PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE** Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare: — First $120 each calendar year — Additional charges	 $0 $0	 $120 $0	 $0 All costs]

PLAN K

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

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

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

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

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

**** ~~[The plan pays the costs that Medicare does not pay after you pay the deductible.]~~ ***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.***

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

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

PLAN K

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

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

~~[** 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.]~~

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

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY ~~[◆◆]~~ *
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First portion of Medicare-approved amounts ~~[equal to the Part B Deductible*]~~ ****	$0	$0	***(*** Part B Deductible ***)*** ~~[**]~~ ****◆
Preventive Benefits for Medicare-covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10%◆
Part B Excess Charges (Above Medicare-approved amounts) ~~[◆◆]~~	$0	$0	All costs ***(and they do not count toward annual out-of-pocket limit)***
BLOOD			
First 3 pints	$0	50%	50%◆
Next portion of Medicare-approved amounts ~~[equal to the Part B Deductible*]~~ ****	$0	$0	***(*** Part B Deductible ***)*** ~~[**]~~ ****◆
Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10%◆
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN K

PARTS A & B

**** This plan limits your annual out-of-pocket payments for Medicare-approved amounts per year.** However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and***

you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

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

~~[**]~~ ***** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the ~~[Guide to Health Insurance for People with Medicare]~~ ***Guide to Health Insurance for People with Medicare,*** which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

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

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

PLAN L

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

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

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

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

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

**** ~~[The plan pays the costs that Medicare does not pay after you pay the deductible.]~~ ***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.***

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

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

PLAN L

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

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

~~[** 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.]~~

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

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY ~~[◆◆]~~ *
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPUTIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: ***First portion of*** Medicare-approved amounts ~~[equal to the Part B Deductible*]~~ ****	$0	$0	***(*** Part B Deductible ***)*** ~~[**]~~ ****◆
Preventive Benefits for Medicare-covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%◆
Part B Excess Charges (Above Medicare-approved amounts) ~~[◆◆]~~	$0	$0	All costs ***(and they do not count toward annual out-of-pocket limit)****
BLOOD First 3 pints ***Next portion of*** Medicare-approved amounts ~~[equal to the Part B Deductible*]~~ ****	$0 $0	75% $0	25%◆ ***(*** Part B Deductible ***)*** ~~[**]~~ ◆
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%◆
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN L

PARTS A & B

~~[** 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.]~~

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

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

******** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the Guide to Health Insurance for People with Medicare, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.***

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY ~~[**]~~ *
HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment: ***First portion of*** Medicare-approved amounts ~~[equal to the Part B Deductible**]~~ *****	$0	$0	***(*** Part B Deductible ***)*** ~~[**]~~ ◆
Remainder of Medicare-approved amounts	80%	15%	5%◆

PLAN M

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

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

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

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

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

PLAN M

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First portion of Medicare-approved amounts*	$0	$0	(Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0

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

PLAN M

PARTS A & B

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

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

PLAN M

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

PLAN N

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

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

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

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

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

PLAN N

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

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

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

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
*First portion of Medicare-approved amounts**	*$0*	*$0*	*(Part B Deductible)*
Remainder of Medicare-approved amounts	*Generally 80%*	*Balance, other than up to ** per office visit and up to ** per emergency room visit. The copayment of up to ** is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.*	*Up to ** per office visit and up to ** per emergency room visit. The copayment of up to ** is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.*
Part B Excess Charges (Above Medicare-approved amounts)	*$0*	*$0*	*All costs*

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

PLAN N

PARTS A & B

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

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

PLAN N

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

Sec. 15. NAC 687B.255 is hereby amended to read as follows:

687B.255 1. An application for a policy to supplement Medicare must include questions designed to elicit information about whether, as of the date of the application, the applicant currently has another policy to supplement Medicare, Medicare Advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether the policy to supplement Medicare or the certificate is intended to replace any other policy or certificate presently in force. A supplementary application or other form containing such questions and statements may be used if it is signed by the applicant and the issuer or its agent.

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

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

(b) ***If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.***

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

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

~~[(d)]~~ ***(e)*** If you are eligible for, and have enrolled in a policy to supplement Medicare by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your policy to supplement Medicare can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your policy to supplement Medicare under these circumstances, and later lose your employer or union-based group health plan, your suspended policy to supplement Medicare or, if that is no longer available, a substantially equivalent policy will be reinstituted if requested

within 90 days of losing your employer or union-based group health plan. If the policy to supplement Medicare provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

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

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

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

To the best of your knowledge,

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

Yes _____ No _____

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

Yes _____ No _____

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

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

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

Yes _____ No _____

If yes,

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

Yes _____ No _____

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

Yes _____ No _____

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

Start ___/___/___ End ___/___/___

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

Yes _____ No _____

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

Yes _____ No _____

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

Yes _____ No _____

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

Yes _____ No _____

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

_____

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

Yes _____ No _____

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

Yes _____ No _____

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

_____

_____

_____

_____

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

Start ___/___/___ End ___/___/___

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

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

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

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

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

7. The notice required by subsection 5:

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

(b) Must be in not less than 12-point type; and

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

NOTICE TO APPLICANT REGARDING REPLACEMENT

OF INSURANCE TO SUPPLEMENT MEDICARE

OR MEDICARE ADVANTAGE

(Insurance company's name and address)

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

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

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

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

I have reviewed the coverage provided by your current policies of medical or health insurance. This policy to supplement Medicare will not duplicate your existing policy to supplement Medicare or, if applicable, Medicare Advantage because you intend to terminate your existing

policy to supplement Medicare or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

_____ Additional benefits.

_____ No change in benefits, but lower premiums.

_____ Fewer benefits and lower premiums.

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

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

_____

_____

_____

_____

_____ Other (please specify).

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

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

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

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

.....

(Signature of Agent, Broker or Other Representative)*

.....

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

.....

(Applicant's Signature)

.....

(Date)

*Signature not required for direct response sales.

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

Sec. 16. NAC 687B.290 is hereby amended to read as follows:

687B.290 1. An issuer who delivers or issues for delivery in this State a policy to supplement Medicare or a certificate on or after July 30, 1992, ***and with an effective date for coverage before June 1, 2010,*** shall make available to each prospective insured a policy or certificate that provides only the following benefits:

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

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

(c) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other

appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days.

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

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

2. In addition to the benefits required by subsection 1, an issuer may make available to prospective insureds any other ***1990*** standardized benefit plans to supplement Medicare as set forth in NAC 687B.295 to 687B.321, inclusive.

Sec. 17. NAC 687B.295 is hereby amended to read as follows:

687B.295 1. Except as otherwise provided in NAC 687B.330, a standardized benefit plan to supplement Medicare may not be delivered or issued for delivery in this State on or after July 30, 1992, ***and with an effective date for coverage before June 1, 2010,*** unless it complies with the provisions of NAC 687B.300 to 687B.321, inclusive.

2. Except as otherwise provided in subsection 4, a ***1990*** standardized benefit plan must:

(a) Have the same style, arrangement, overall content and designation as the ***1990*** standardized benefit plans set forth in NAC 687B.300 to 687B.321, inclusive.

(b) Conform to the definitions set forth in NAC 687B.201 to 687B.2045, inclusive.

3. Each benefit ***for a 1990 standardized benefit plan*** must be structured in accordance with the format and listed in the order indicated in NAC 687B.300 to 687B.321, inclusive.

4. In addition to the designations for ***1990*** standardized benefit plans set forth in NAC 687B.300 to 687B.321, inclusive, an issuer may use other designations if he obtains the prior approval of the Commissioner.

Sec. 18. NAC 687B.300 is hereby amended to read as follows:

687B.300 A ***1990 standardized*** benefit plan to supplement Medicare which is designated as Standardized Benefit Plan A must be limited to the benefits required by NAC 687B.290.

Sec. 19. NAC 687B.302 is hereby amended to read as follows:

687B.302 A ***1990 standardized*** benefit plan to supplement Medicare which is designated as Standardized Benefit Plan B must provide the following benefits:

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

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

Sec. 20. NAC 687B.304 is hereby amended to read as follows:

687B.304 A ***1990 standardized*** benefit plan to supplement Medicare which is designated as Standardized Benefit Plan C must provide the following benefits:

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

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

3. For Medicare Part A eligible expenses for posthospital care received at a skilled nursing facility, coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in any Medicare benefit period.

4. Coverage for all of the Medicare Part B deductible amount per calendar year, regardless of whether the insured has been confined in a hospital.

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

Sec. 21. NAC 687B.306 is hereby amended to read as follows:

687B.306 A ***1990 standardized*** benefit plan to supplement Medicare which is designated as Standardized Benefit Plan D must provide the following benefits:

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

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

3. For Medicare Part A eligible expenses for posthospital care received at a skilled nursing facility, coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in any Medicare benefit period.

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

5. Coverage for short-term services that provide to a person recovering from an illness, injury or surgery in his home, assistance with daily activities such as bathing, dressing, personal hygiene, eating, ambulating, administering prescription drugs and changing bandages and other dressings. The coverage must comply with the requirements of NAC 687B.325.

Sec. 22. NAC 687B.308 is hereby amended to read as follows:

687B.308 A ***1990 standardized*** benefit plan to supplement Medicare which is designated as Standardized Benefit Plan E must provide the following benefits:

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

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

3. For Medicare Part A eligible expenses for posthospital care received at a skilled nursing facility, coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in any Medicare benefit period.

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

5. Coverage for the following preventative health services for the actual amount charged for each service not to exceed 100 percent of the amount approved by Medicare for that service, as

identified in the American Medical Association's Current Procedural Terminology (AMA CPT) codes, not to exceed $120 per year, and to the extent not covered by Medicare:

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

(b) Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

Sec. 23. NAC 687B.311 is hereby amended to read as follows:

687B.311 1. A ***1990 standardized*** benefit plan to supplement Medicare which is designated as Standardized Benefit Plan F or High Deductible Benefit Plan F must provide the following benefits:

(a) The benefits required by NAC 687B.290.

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

(c) For Medicare Part A eligible expenses for posthospital care received at a skilled nursing facility, coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in any Medicare benefit period.

(d) Coverage for all of the Medicare Part B deductible amount per calendar year, regardless of whether the insured has been confined in a hospital.

(e) Coverage for 100 percent of the Medicare Part B excess charge calculated by determining the difference between the actual Medicare Part B charge as billed, not to exceed any limitation on that charge established by the Medicare program or state law, and the Medicare Part B charge that has been approved.

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

2. In addition to the requirements of subsection 1, a ***1990 standardized*** benefit plan to supplement Medicare which is designated as High Deductible Benefit Plan F must require the insured to pay an annual deductible. The annual deductible for High Deductible Benefit Plan F is subject to change. For the current deductible, please consult the most current version of the *Guide to Health Insurance for People with Medicare* **,** which must be provided by an issuer to an applicant pursuant to NAC 687B.240. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to NAC 687B.250 must specify the current amount of the deductible. The annual deductible for High Deductible Benefit Plan F may be adjusted annually by the Secretary of the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for All Urban Consumers published by the United States Department of Labor for the calendar year ending on July 31 of the immediately preceding year, and rounded to the nearest multiple of $10. The deductible must be paid in addition to the premium and in addition to any other deductibles relating to a specific benefit.

Sec. 24. NAC 687B.313 is hereby amended to read as follows:

687B.313 A ***1990 standardized*** benefit plan to supplement Medicare which is designated as Standardized Benefit Plan G must provide the following benefits:

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

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

3. For Medicare Part A eligible expenses for posthospital care received at a skilled nursing facility, coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in any Medicare benefit period.

4. Coverage for 80 percent of the Medicare Part B excess charge calculated by determining the difference between the actual Medicare Part B charge as billed, not to exceed any limitation on that charge established by the Medicare program or state law, and the Medicare Part B charge that has been approved.

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

6. Coverage for short-term services that provide to a person recovering from an illness, injury or surgery in his home, assistance with daily activities such as bathing, dressing, personal hygiene, eating, ambulating, administering prescription drugs and changing bandages and other dressings. The coverage must comply with the requirements of NAC 687B.325.

Sec. 25. NAC 687B.315 is hereby amended to read as follows:

687B.315 A ***1990 standardized*** benefit plan to supplement Medicare which is designated as Standardized Benefit Plan H must provide the following benefits:

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

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

3. For Medicare Part A eligible expenses for posthospital care received at a skilled nursing facility, coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in any Medicare benefit period.

4. For plans sold or issued before January 1, 2006, as a basic benefit, coverage is provided for 50 percent of the charges for prescription drugs received as an outpatient, after payment of a deductible of $250 per calendar year, not to exceed $1,250 in benefits received by the insured per calendar year, and to the extent not covered by Medicare. This subsection only applies to those persons currently covered by Plan H and who do not apply for Medicare Part D.

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

Sec. 26. NAC 687B.317 is hereby amended to read as follows:

687B.317 A ***1990 standardized*** benefit plan to supplement Medicare which is designated as Standardized Benefit Plan I must provide the following benefits:

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

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

3. For Medicare Part A eligible expenses for posthospital care received at a skilled nursing facility, coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in any Medicare benefit period.

4. Coverage for 100 percent of the Medicare Part B excess charge calculated by determining the difference between the actual Medicare Part B charge as billed, not to exceed any limitation on that charge established by the Medicare program or state law, and the Medicare Part B charge that has been approved.

5. For plans sold or issued before January 1, 2006, as a basic benefit, coverage is provided for 50 percent of the charges for prescription drugs received as an outpatient, after payment of a deductible of $250 per calendar year, not to exceed $1,250 in benefits received by the insured per calendar year, to the extent not covered by Medicare. This subsection only applies to those persons currently covered by Plan I and who do not apply for Medicare Part D.

6. Coverage of Medicare eligible expenses for 80 percent of the billed charges for medically necessary emergency care received in a foreign country to the extent not covered by Medicare, if such care would have been covered by Medicare if provided in the United States and the care began during the first 60 consecutive days of the trip outside the United States. The benefit is subject to the payment of a deductible of $250 per calendar year and a lifetime maximum benefit

of $50,000. As used in this subsection, “emergency care” means medical care needed immediately because of a sudden and unexpected injury or illness.

7. Coverage for short-term services that provide to a person recovering from an illness, injury or surgery in his home, assistance with daily activities such as bathing, dressing, personal hygiene, eating, ambulating, administering prescription drugs and changing bandages and other dressings. The coverage must comply with the requirements of NAC 687B.325.

Sec. 27. NAC 687B.319 is hereby amended to read as follows:

687B.319 1. A ***1990 standardized*** benefit plan to supplement Medicare which is designated as Standardized Benefit Plan J or High Deductible Benefit Plan J must provide the following benefits:

(a) The benefits required by NAC 687B.290.

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

(c) For Medicare Part A eligible expenses for posthospital care received at a skilled nursing facility, coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in any Medicare benefit period.

(d) Coverage for all of the Medicare Part B deductible amount per calendar year, regardless of whether the insured has been confined in a hospital.

(e) Coverage for 100 percent of the Medicare Part B excess charge calculated by determining the difference between the actual Medicare Part B charge as billed, not to exceed any limitation on that charge established by the Medicare program or state law, and the Medicare Part B charge that has been approved.

(f) For plans sold or issued before January 1, 2006, as an extended benefit, coverage is provided for 50 percent of the charges for prescription drugs received as an outpatient, after payment of a deductible of $250 per calendar year, not to exceed $3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare. This paragraph only applies to those persons currently covered by Plan J and who do not apply for Medicare Part D.

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

(h) Coverage for the following preventative health services for the actual amount charged for each service not to exceed 100 percent of the amount approved by Medicare for that service, as identified in the American Medical Association’s Current Procedural Terminology (AMA CPT) codes, not to exceed $120 per year, to the extent not covered by Medicare:

(1) An annual clinical medical history and physical examination that may include the tests and services set forth in subparagraph (2) and educational services that address measures to be taken for preventative health care.

(2) Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

(i) Coverage for short-term services that provide to a person recovering from an illness, injury or surgery in his home, assistance with daily activities such as bathing, dressing, personal

hygiene, eating, ambulating, administering prescription drugs and changing bandages and other dressings. The coverage must comply with the requirements of NAC 687B.325.

2. In addition to the requirements of subsection 1, a ***1990 standardized*** benefit plan to supplement Medicare which is designated as High Deductible Benefit Plan J must require the insured to pay an annual deductible. The annual deductible for High Deductible Benefit Plan J is subject to change. For the current deductible, please consult the most current version of the *Guide to Health Insurance for People with Medicare* **,** which must be provided by an issuer to an applicant pursuant to NAC 687B.240. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to NAC 687B.250 must specify the current amount of the deductible. The annual deductible for High Deductible Benefit Plans F and J may be adjusted annually by the Secretary of Health and Human Services to reflect the change in the Consumer Price Index for All Urban Consumers published by the United States Department of Labor for the calendar year ending on July 31 of the immediately preceding year, and rounded to the nearest multiple of $10. The deductible must be paid in addition to the premium and in addition to any other deductibles relating to a specific benefit.

Sec. 28. NAC 687B.320 is hereby amended to read as follows:

687B.320 A ***1990 standardized*** benefit plan to supplement Medicare which is designated as Standardized Benefit Plan K must provide the following benefits:

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

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

3. Coverage for 50 percent of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for posthospital skilled nursing facility care

eligible under Medicare Part A until the out-of-pocket limitation is met as described in subsection 8.

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

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

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

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

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

Sec. 29. NAC 687B.321 is hereby amended to read as follows:

687B.321 A ***1990 standardized*** benefit plan to supplement Medicare which is designated as Standardized Benefit Plan L must provide the following benefits:

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

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

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

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

5. Coverage for 75 percent, under Medicare Part A or B, of the reasonable cost of the first 3 pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations, until the out-of-pocket limitation is met as described in subsection 8.

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

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

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

Sec. 30. NAC 687B.325 is hereby amended to read as follows:

687B.325 1. ~~[Coverage]~~ ***For a 1990 standardized benefit plan, coverage*** for short-term services provided to a person recovering from an illness, injury or surgery in his home must comply with the following requirements:

(a) The insured's attending physician must certify that the specific type and frequency of recovery services provided at home are necessary because of a condition for which a plan of treatment provided at home was approved by Medicare.

(b) Coverage must be limited to:

(1) No more than the number and type of recovery visits certified as necessary by the insured's attending physician. The total number of recovery visits may not exceed the number of visits approved by Medicare pursuant to a plan of treatment provided at home that has been approved by Medicare.

(2) The actual charges for each recovery visit not to exceed a maximum reimbursement of $40 per visit.

(3) A maximum reimbursement of $1,600 per calendar year.

(4) Seven visits in any 1 week.

(5) Care furnished on a visiting basis in the insured's home.

(6) Services provided by a provider of health care.

(7) Recovery visits received:

(I) While the insured is covered under the policy to supplement Medicare or the certificate and not otherwise excluded.

(II) During the period the insured is receiving services at home which are approved by Medicare or no later than 8 weeks after the date of the last recovery visit approved by Medicare.

(c) Coverage must be excluded for:

(1) Recovery visits paid for by Medicare or another governmental program.

(2) Care provided by members of the insured's family, unpaid volunteers or other persons who are not providers of health care.

2. As used in this section:

(a) "Home" means any location used by the insured as a place of residence if that location would qualify as a residence for health care services provided at home which are covered by Medicare. The term does not include a hospital or skilled nursing facility.

(b) "Provider of health care" means a qualified or licensed aide or homemaker who provides health care in the home, an aide who provides personal care or a nurse provided through a licensed agency for home health care or referred by a licensed referral agency or licensed registry for nurses.

(c) "Recovery visit" means a visit required to provide care to the insured at home, without a limit on the duration of the visit, except each consecutive 4 hours of services in a 24-hour period is one visit.

NOTICE OF ADOPTION OF PROPOSED REGULATION
LCB File No. R049-09

The Commissioner of Insurance adopted regulations which pertain to chapter 687B of the Nevada Administrative Code.

INFORMATIONAL STATEMENT

A workshop was held on October 14, 2009, and a hearing was held on October 21, 2009, at the offices of the Department of Business and Industry, Division of Insurance ("Division"), 788 Fairview Drive, Suite 300, Carson City, Nevada 89701, with a simultaneous video-conference conducted at the Bradley Building, 2501 E. Sahara Avenue, Real Estate Division Conference Room, 2nd Floor, Las Vegas, Nevada 89104, regarding the adoption of the permanent regulation concerning Medicare Supplement Policies.

Public comment was solicited by posting notice of the hearing in the following public locations: 788 Fairview Drive, Legislative Counsel Bureau, Capitol Building Lobby, Blasdel Building, Carson City Courthouse, State Library, Carson City Library, Clark County Library, Churchill County Library, Douglas County Library, Elko County Library, Esmeralda County Library, Eureka Branch Library, Humboldt County Library, Lander County Library, Lincoln County Library, Mineral County Library, Lyon County Library, Tonopah Public Library, Pershing County Library, Storey County Library, Washoe County Library, White Pine County Library, Capitol Press Room, the Donald W. Reynolds Press Center, the Office of the Attorney General, and the Division's Las Vegas Office.

The Division maintains a list of interested parties, comprised mainly of insurance companies, agencies and other persons regulated by the Division. These persons were notified of the workshop and hearing, and that copies of the regulation could be obtained from or examined at the offices of the Division in Carson City.

The workshop was attended by 12 interested parties in Carson City and 3 interested parties in Las Vegas. The Division received written comments from Leanne Gassaway of America's Health Insurance Plans ("AHIP"). Oral testimony, in the form of suggested changes to the existing regulation, was provided by Jack Childress, representing the Division. Public comment was heard from Jack Kim, representing United HealthCare.

The hearing was attended by 10 interested parties in Carson City and 2 interested parties in Las Vegas. During the hearing, oral testimony was provided by Jack Childress, representing the Division. No written testimony or public comment was heard from any other interested parties.

There were several amendments recommended and made to the proposed permanent regulation, LCB File No. R049-09. A revised version of the proposed permanent regulation is attached. The proposed permanent regulation amends Chapter 687B of the Nevada Administrative Code ("NAC") to comply with the federal requirements of the Medicare

Improvements for Patients and Providers Act of 2008 ("MIPPA") and the Genetic Information Nondiscrimination Act of 2008 ("GINA").

Based upon the testimony received at the hearing, the proposed permanent regulation[1] is amended as follows:

1. Section 1 has been amended to read as follows:

Chapter 687B of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to [~~6~~]7, inclusive, of this regulation[~~:~~].

2. Section 2 has been amended to read as follows:

"1990 standardized benefit plan to supplement Medicare[~~,~~]" or "1990 standardized benefit plan" [~~or "1990 plan"~~] means a [~~group or individual~~] policy [~~of insurance~~] to supplement Medicare issued on or after January 1, 1992, and with an effective date for coverage [~~prior to~~]before June 1, 2010, and includes policies to supplement Medicare and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured.

3. Section 3 has been amended to read as follows:

"2010 standardized benefit plan to supplement Medicare[~~,~~]" or "2010 standardized benefit plan" [~~or "2010 plan"~~] means a [~~group or individual~~] policy [~~of insurance~~] to supplement Medicare issued with an effective date for coverage on or after June 1, 2010.

4. Section 4 has been amended to read as follows:

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[1] The changes shown in the Summary of Proceedings include: 1) the revised changes made after the workshop which were incorporated into the LCB Draft of Revised Proposed Regulation R049-09 received by the Division of Insurance on October 19, 2009 ("LCB Draft"); and 2) the five changes to the LCB Draft as testified to by Jack Childress in the Hearing held on October 21, 2009. Any prior changes to the Proposed Permanent Regulation R049-09 are not included in this Summary.

1. On or after June 1, 2010, no policy or certificate may be advertised, solicited, delivered or issued for delivery in this State as a policy to supplement Medicare or certificate unless it complies with the standards provided for in sections 5 and 6 of this regulation.

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

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

5. Section 5 has been amended to read as follows:

1. In addition to the standards set forth in section 6 of this regulation, the standards provided for in this section are:

(a) Applicable to all policies to supplement Medicare or certificates delivered or issued for delivery in this State with an effective date for coverage on or after June 1, 2010; and

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

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

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

(1) [e]Exclude or limit benefits for losses incurred more than 6 months [from]after the effective date of coverage because [it involved]of a preexisting condition[, and the policy or certificate may not].

(2) [~~d~~]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[~~;~~].

[~~(b) A policy to supplement Medicare or certificate must not~~]

(3) [~~i~~]Indemnify against any loss[~~es~~] resulting from sickness on a different basis than for a loss[~~es~~] resulting from an accident[~~s;~~].

[~~(c)~~](b) A policy to supplement Medicare or a certificate must provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment or coinsurance amounts[~~,~~]. [~~and p~~]Premiums may be modified to correspond with such changes[~~;~~].

[~~(d)~~](c) No policy to supplement Medicare or certificate may provide for the termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium[~~;~~]s.

[~~(e)~~](d) [~~Each~~]A policy to supplement Medicare must be guaranteed renewable and:

(1) The issuer shall not cancel or fail to renew [~~a~~]the policy solely [~~on the grounds~~]because of the health status of the person;

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

[~~(3)~~](e) If [~~the~~]a policy to supplement Medicare is terminated by [~~a~~]the group policyholder and is not replaced as provided under [~~sub~~]paragraph [~~(5)~~](g), the issuer shall offer to each certificate holder[~~s~~] an individual policy to supplement Medicare which, at the option of the certificate holder:

[~~(I)~~](1) Provides for the continuation of the benefits contained in the group policy; or

[~~(II)~~](2) Provides [~~for~~] benefits that otherwise meet the requirements of this subsection[~~;~~].

[~~(4)~~](f) If a person is a certificate holder in a group policy to supplement Medicare and the person terminates membership in the group, the issuer shall:

[~~(I)~~](1) Offer the certificate holder the conversion opportunity described in [~~sub~~]paragraph [~~(3)~~](e); or

[~~(II)~~](2) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy[~~; and~~].

[~~(5)~~](g) If a group policy to supplement Medicare is replaced by another group policy to supplement Medicare which is purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the previous group policy on its date of termination[~~,~~]. [~~and c~~]Coverage under the new policy must not result in [~~any~~]the exclusion for preexisting conditions that would have been covered under the group policy being replaced[~~;~~].

[~~(f)~~](h) Termination of a policy to supplement Medicare or a certificate must be without prejudice to any continuous loss [~~which~~]that commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, and limited to the duration of the policy benefit period, if any, or to the payment of the maximum benefits[~~, and~~]. The receipt of Medicare Part D benefits will not be considered in determining a continuous loss[~~;~~].

[~~(g)~~](i) A policy to supplement Medicare or a certificate must provide that benefits and premiums under the policy or certificate must be suspended at the request of the policyholder or certificate holder for the period, not to exceed 24 months, [~~in~~]during which the policyholder or certificate holder has applied for and is determined to be [~~entitled to~~]eligible for medical assistance under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 et seq., [~~but only~~] if the policyholder or certificate holder notifies the issuer of the policy or certificate within 90 days after the date the person becomes [~~entitled to~~]eligible for such assistance[~~;~~].

[~~(h)~~] If [~~suspension occurs~~]benefits or premiums are suspended and [~~if~~] the policyholder or certificate holder loses [~~entitlement to~~]eligibility for such medical assistance, the policy or certificate must be automatically [~~reinstituted~~]reinstated effective as of the date eligibility is terminat[~~ion~~]ed [~~of entitlement~~] if the policyholder or certificate holder provides notice of loss of [~~entitlement~~]eligibility to the insurer within 90 days after the date of loss and pays the premium attributable to the period[~~, effective as of the date of termination of entitlement;~~]of eligibility.

[~~(i) Each~~](j) A policy to supplement Medicare or a certificate must provide that benefits and premiums under the policy must be suspended at the request of the policyholder for any period that may be provided by federal regulation [~~at the request of the policyholder~~] if the policyholder is entitled to benefits under section 226(b) of the Social Security Act, 42 U.S.C. § 426(b), and is covered under a group health plan as defined in section 1862(b)(1)(A)(v) of the Social Security Act, 42 U.S.C. § 1395y(b)(1)(A)(v)[~~, and, i~~]. If [~~suspension occurs~~]benefits and premiums are suspended and [~~if~~] the policyholder or certificate holder loses coverage under the group health plan, the policy must be automatically [~~reinstituted~~]reinstated, effective as of the date of loss of coverage[~~,~~] if the policyholder provides notice of loss of coverage within 90 days

after the date of the loss and pays the premium attributable to the period[~~, effective as of the date of termination of enrollment in the group health plan; and~~].

[~~(j) Reinstitution~~](k) Reinstatement of coverage as described in paragraphs [~~(h)~~](i) and [~~(i)~~](j):

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

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

(3) Must provide for the classification of premiums on terms at least as favorable to the policyholder or certificate holder as the [~~premium classification~~] terms [~~that would have applied to the policyholder or certificate holder had the coverage not been~~]in effect before the benefits and premiums were suspended.

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

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

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

(c) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days, and the provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance[~~;~~].

(d) Coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations[~~;~~].

(e) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible[~~; and~~].

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

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

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

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

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

(d) Coverage for 100 percent of the Medicare Part B deductible amount per calendar year regardless of hospital confinement;

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

(f) Coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare[-]eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000[~~, and, f~~]. For purposes of this [~~benefit~~]paragraph, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

6. Section 6 has been amended to read as follows:

1. In addition to the standards set forth in section 5 of this regulation, the standards provided for in this section are:

(a) Applicable to all policies to supplement Medicare or certificates delivered or issued for delivery in this State with an effective date for coverage on or after June 1, 2010; and

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

2. On or after June 1, 2010, an issuer shall make available to each prospective policyholder or certificate holder a policy form or certificate form containing only the basic core benefits, as [~~defined~~]set forth in subsection 3 of section 5 of this regulation.

3. On or after June 1, 2010, if an issuer makes available any of the additional benefits [~~described~~]set forth in subsection 4 of section 5 of this regulation, or offers Standardized Benefit Plan[~~s~~] K or L as described in paragraphs (h) and (i) of subsection 7, the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic core benefits as described in subsection 2, a policy form or certificate form containing either Standardized Benefit Plan C as described in paragraph (c) of subsection 7 or Standardized Benefit Plan F as described in paragraph (e) of subsection 7.

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

5. On or after June 1, 2010, a benefit plan[~~s~~] must be uniform in structure, language, designation and format to the standard benefit plans listed in this [~~sub~~]section and must conform to the definition in section 3 of this regulation[~~, and c~~]. Each benefit must be structured in accordance with the format provided in subsections 3 and 4 of section 5 of this regulation or, in the case of Standardized Benefit [~~p~~]Plan[~~s~~] K or L, in paragraphs (h) and (i) of subsection 7, and list the benefits in the order shown in the applicable requirements.

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

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

(a) A 2010 standardized benefit plan to supplement Medicare which is designated as Standardized Benefit Plan A must include only the basic core benefits as defined in subsection 3 of section 5 of this regulation[~~;~~].

(b) A 2010 standardized benefit plan to supplement Medicare which is designated as Standardized Benefit Plan B must include only the basic core benefits as defined in subsection 3 of section 5 of this regulation, plus 100 percent of the Medicare Part A deductible as defined in paragraph (a) of subsection 4 of section 5 of this regulation[~~;~~].

(c) A 2010 standardized benefit plan to supplement Medicare which is designated as Standardized Benefit Plan C must include only the basic core benefits as defined in subsection 3 of section 5 of this regulation, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in paragraphs (a), (c), (d) and (f) of subsection 4 of section 5 of this regulation, respectively[~~;~~].

(d) A 2010 standardized benefit plan to supplement Medicare which is designated as Standardized Benefit Plan D must include only the basic core benefits as defined in subsection 3 of section 5 of this regulation, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs (a), (c) and (f) of subsection 4 of section 5 of this regulation, respectively[~~;~~].

(e) A 2010 standardized benefit plan to supplement Medicare which is designated as Standardized Benefit Plan F must include only the basic core benefits as defined in subsection 3 of section 5 of this regulation, plus 100 percent of the Medicare Part A deductible, the skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (a), (c), (d), (e) and (f) of subsection 4 of section 5 of this regulation, respectively[~~;~~].

(f) A 2010 standardized benefit plan to supplement Medicare which is designated as High Deductible Benefit Plan F:

(1) Must include only 100 percent of covered expenses following the payment of the annual deductible set forth in subparagraph (2) and the basic core benefits as defined in subsection 3 of section 5 of this regulation, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (a), (c), (d), (e) and (f) of subsection 4 of section 5 of this regulation, respectively; and

(2) Has an annual deductible that:

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

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

(III) Has a bas[~~is~~]e which must be $1,500 and must be adjusted annually from 1999 by the Secretary of the United States Department of Health and Human Services to reflect the

change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10[~~;~~].

(g) A 2010 standardized benefit plan to supplement Medicare which is designated as Standardized Benefit Plan G must include only the basic core benefits as defined in subsection 3 of section 5 of this regulation, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (a), (c), (e) and (f) of subsection 4 of section 5 of this regulation, respectively[~~;~~].

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

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

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

(3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days, and the provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(4) Coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph (10);

(5) Coverage for 50 percent of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subparagraph (10);

(6) Coverage for 50 percent of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph (10);

(7) Coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first 3 pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations, until the out-of-pocket limitation is met as described in subparagraph (10);

(8) Except for coverage provided in subparagraph (9), coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in subparagraph (10);

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

(10) Coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the person has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4,000 in 2006, indexed each year by the

appropriate inflation adjustment specified by the Secretary of the United States Department of Health and Human Services[;].

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

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

(2) The benefits described in subparagraphs (4)[, (5), (6), (7) and] to (8), inclusive, of paragraph (h), but substituting 75 percent for 50 percent; and

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

(j) A 2010 standardized benefit plan to supplement Medicare which is designated as Standardized Benefit Plan M must include only the basic core benefits as defined in subsection 3 of section 5 of this regulation, plus 50 percent of the Medicare Part A deductible, skilled nursing facility care and medically necessary emergency care in a foreign country as defined in paragraphs (b), (c) and (f) of subsection 4 of section 5 of this regulation, respectively[; and].

(k) A 2010 standardized benefit plan to supplement Medicare which is designated as Standardized Benefit Plan N must include only the basic core benefits as defined in subsection 3 of section 5 of this regulation, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care and medically necessary emergency care in a foreign country as defined in

paragraphs (a), (c) and (f) of subsection 4 of section 5 of this regulation, respectively, with coinsurance or copayments in the following amounts:

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

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

8. On or after June 1, 2010, an issuer may, with the prior approval of the Commissioner, offer [policies]a policy to supplement Medicare or a certificate[s] with new or innovative benefits[,] in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards, and:

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

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

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

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

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

7. Section 7 has been amended to read as follows:

1. An issuer of a policy to supplement Medicare or a certificate:

(a) Shall not deny or condition the issuance or effectiveness of the policy or certificate, including, without limitation, the imposition of any exclusion of benefits under the policy based on a preexisting condition, on the basis of the genetic information of a person; and

(b) Shall not discriminate in the pricing of the policy or certificate, including, without limitation, the adjustment of premium rates, of a person on the basis of the genetic information of the person.

2. Nothing in subsection 1 shall be construed to limit the ability of an issuer of a policy to supplement Medicare or a certificate, to the extent otherwise permitted by law, from:

(a) Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or

(b) Increasing the premium for any policy issued to a person based on the manifestation of a disease or disorder of a person who is covered under the policy[~~, and in such case, t~~]. The manifestation of a disease or disorder in one person cannot also be used as genetic information about other group members and to further increase the premium for the group.

3. An issuer of a policy to supplement Medicare or a certificate shall not request or require a person or a family member of the person to undergo a genetic test.

4. The provisions in [~~S~~]subsection 3 must not be construed to preclude an issuer of a policy to supplement Medicare or certificate from obtaining and using the results of a genetic test in making a determination regarding payment as defined for the purposes of applying the

regulations promulgated under Part C of Title XI and section 264 of the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. §§ 1320d et seq., and note to 42 U.S.C.[A.] § 1320d-2, as may be revised from time to time, and consistent with the provisions of subsection 1.

5. For the purposes of carrying out subsection 4, an issuer of a policy to supplement Medicare or a certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

6. Notwithstanding the provisions of subsection 3, an issuer of a policy to supplement Medicare or a certificate may request, but not require, that a person or a family member of the person undergo a genetic test if[each of the following conditions is met]:

(a) The request is made pursuant to research that complies with [Part 46 of Title 45 of the Code of Federal Regulations,] 45 C.F.R. § 46.101 et. seq., or equivalent federal regulations, and any applicable state or local law or regulations for the protection of human subjects in research;

(b) The issuer clearly indicates to each person, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that:

(1) Compliance with the request is voluntary; and

(2) Noncompliance will have no effect on enrollment status or premium or contribution amounts;

(c) [No]Any genetic information collected or acquired under this subsection [may be]is not used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal or replacement of a policy or certificate;

(d) The issuer notifies the Secretary of the United States Department of Health and Human Services in writing that the issuer is conducting activities pursuant to the exception provided for under this subsection, including a description of the activities conducted; and

(e) The issuer complies with such other conditions as the Secretary of the United States Department of Health and Human Services may, by regulation, require for activities conducted under this subsection.

7. An issuer of a policy to supplement Medicare or a certificate shall not request, require or purchase genetic information for underwriting purposes.

8. An issuer of a policy to supplement Medicare or a certificate shall not request, require, or purchase genetic information with respect to any person [~~prior to~~]before the person's enrollment under the policy in connection with such enrollment.

9. If an issuer of a policy to supplement Medicare or a certificate obtains genetic information incidental to the requesting, requiring or purchasing of other information concerning any person, such request, requirement or purchase must not be considered a violation of the provisions of subsection 8 if such request, requirement or purchase is not in violation of the provisions of subsection 7.

10. As used in this section:

(a) "Family member" means, with respect to a person, any other person who is a first[-]degree, second[-]degree, third[-]degree or fourth[-]degree relative of the person.

(b) "Genetic information" means, with respect to any person, information about [~~the~~]a genetic test of the person[~~'s genetic tests~~], the genetic tests of family members of the person, and the manifestation of a disease or disorder in family members of the person, and any request for, or receipt of, genetic services, or participation in clinical research which includes

genetic services, by the person or any family member of the person. Any reference to "genetic information" concerning a person or family member of the person who is a pregnant woman includes, without limitation, genetic information of any fetus carried by such pregnant woman, or, with respect to the person or family member utilizing reproductive technology, includes, without limitation, genetic information of any embryo legally held by the person or family member. The term does not include information about the sex or age of any person.

(c) "Genetic services" means a genetic test, genetic education and genetic counseling, including obtaining, interpreting or assessing genetic information.

(d) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites[~~,~~] that detects genotypes, mutations or chromosomal changes. The term does not include:

(1) An analysis of proteins or metabolites that does not detect genotypes, mutations or chromosomal changes; or

(2) An analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the applicable field of medicine[~~involved~~].

(e) "Issuer of a policy to supplement Medicare or a certificate" includes third-party administrator, or other person acting for or on behalf of such issuer.

(f) "Underwriting purposes" means:

(1) Rules for, or determination of, eligibility, including, without limitation, enrollment and continued eligibility for benefits under the policy;

(2) The computation of premium or contribution amounts under the policy;

(3) The application of any preexisting condition exclusion under the policy; and

(4) Other activities related to the creation, renewal or replacement of a contract of health insurance or health benefits.

8. Subsection 1 of section 10 has been amended to read as follows:

1. Except as otherwise provided in paragraphs (a) and (b) of subsection 2 of NAC 687B.226 and paragraphs (a) and (b) of subsection 2 of NAC 687B.227**,** and subparagraphs (1) and (2) of paragraph (a) of subsection 2 of section 5 of this regulation, a policy or certificate may not be advertised, solicited or issued for delivery in this State as a policy to supplement Medicare if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

9. Section 13 has been 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, and with an effective date [~~of~~]for coverage [~~prior to~~]before June 1, 2010, if it fails to comply with the requirements set forth in this section.

2. A policy to supplement Medicare or a certificate originally delivered or issued for delivery, or renewed, in this State on or after July 30, 1992**,** and with an effective date for coverage [~~prior to~~]before June 1, 2010, 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**,** copayment or coinsurance amounts. Premiums may be modified to correspond with such changes.

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

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

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

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

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

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

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

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

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, if the suspended policy to supplement Medicare provided coverage for outpatient prescription drugs, [~~reinstitution~~]reinstatement of the policy for Medicare Part D enrollees must be without coverage for outpatient prescription drugs and must otherwise provide substantially equivalent coverage to the coverage in effect before the [~~date of suspension~~]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.

11. If an issuer makes a written offer to the Medicare Supplement policyholder or certificate holder of one or more of its plans[~~,~~] to exchange, during a specified period, from his or her 1990 [~~S~~]standardized benefit plan, as described in NAC 687B.295, to a 2010 [S]standardized benefit plan, as described in section 6 of this regulation, the offer and subsequent exchange must comply with the following requirements:

(a) [~~An~~]The issuer need not provide justification to the Commissioner if the insured replaces a 1990 [~~S~~]standardized benefit [~~policy~~]plan or certificate with an issue age rated 2010 [~~S~~]standardized benefit [~~policy~~]plan or certificate at the insured's original issue age and duration;

(b) If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of such offer, the rate charged to the insured for the new exchanged policy must recognize the policy reserve buildup, due to the prefunding inherent in the use of an issue age rate basis, for the benefit of the insured;

(c) The method proposed to be used by an issuer must be filed with the Commissioner pursuant to NAC 687B.229;

(d) The rating class of the new policy or certificate must be the class closest to the insured's class of the replaced coverage;

(e) [~~An~~]The issuer may not apply new limitations on preexisting conditions [~~limitations~~] or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 [~~S~~]standardized benefit [~~policy~~]plan or certificate of the insured, but may apply [~~preexisting condition~~] limitations of not more than 6 months on preexisting conditions to any added benefits contained in the new 2010 [S]standardized benefit [~~policy~~]plan or certificate not contained in the exchanged policy; and

(f) The new policy or certificate must be offered to all policyholders or certificate holders within a given plan, except where the offer or issue would be in violation of state or federal law.

10. Section 14 has been amended to read as follows:

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

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

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

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

(a) A cover page;

(b) Information regarding premiums;

(c) Disclosure pages; and

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

4. All plans must be shown on the cover page, and the plans offered by the issuer must be prominently identified.

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

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

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

Benefit Chart of Medicare Supplement Plans Sold with an Effective Date for Coverage on or after June 1, 2010

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

Plans E, H, I and J are no longer available for sale. [This sentence must not appear after June 1, 2011.]

Basic Benefits:

Hospitalization - Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses - Part B coinsurance (generally 20 percent of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.

Blood - First three pints of blood each year.

Hospice - Part A coinsurance.

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

Part A Deductible	Part A Deductible Part B Deductible Foreign Travel Emergency	Part A Deductible Foreign Travel Emergency	Part A Deductible Part B Deductible Part B Excess (100%) Foreign Travel Emergency	Part A Deductible Part B Excess (100%) Foreign Travel Emergency	50% Part A Deductible Out-of-pocket limit**; paid at 100% after limit reached	75% Part A Deductible Out-of-pocket limit**; paid at 100% after limit reached	50% Part A Deductible Foreign Travel Emergency	Part A Deductible Foreign Travel Emergency

* Plan F also has an option called a High Deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year deductible. Benefits from [~~h~~]High [~~d~~]Deductible [~~p~~]Plan F will not begin until out-of-pocket expenses exceed the deductible. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

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

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

PREMIUM INFORMATION (Boldface type)

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

DISCLOSURES (Boldface type)

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold [~~for~~]with effective dates on or after June 1, 2010. Policies sold [~~for~~]with effective dates [~~prior to~~]before June 1, 2010, have

different benefits and premiums. Plans E, H, I and J are no longer available for sale. (This paragraph must not appear after June 1, 2010.)

READ YOUR POLICY VERY CAREFULLY

(Boldface type)

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

RIGHT TO RETURN POLICY (Boldface type)

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

POLICY REPLACEMENT (Boldface type)

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

NOTICE (Boldface type)

This policy may not cover all of your medical costs.

(For agents)

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

(For direct response)

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

This outline of coverage does not give all the details of Medicare coverage. Contact your local social security office or consult Medicare & You for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

(Boldface type)

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

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

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

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

PLAN A

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

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

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: First portion of Medicare-approved amounts* Remainder of Medicare-approved amounts	 $0 Generally 80%	 $0 Generally 20%	 (Part B Deductible) $0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD First 3 pints Next portion of Medicare-approved amounts* Remainder of Medicare-approved amounts	$0 $0 80%	All costs $0 20%	$0 (Part B Deductible) $0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN A

PARTS A & B

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

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

PLAN B

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

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

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

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

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

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: First portion of Medicare-approved amounts* Remainder of Medicare-approved amounts	 $0 Generally 80%	 $0 Generally 20%	 (Part B Deductible) $0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD First 3 pints Next portion of Medicare-approved amounts* Remainder of Medicare-approved amounts	$0 $0 80%	All costs $0 20%	$0 (Part B Deductible) $0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN B

PARTS A & B

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

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

PLAN C

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

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

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

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

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

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First portion of Medicare-approved amounts*	$0	(Part B Deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next portion of Medicare-approved amounts*	$0	(Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN C

PARTS A & B

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

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

PLAN C

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

PLAN D

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

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

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

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

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

PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: First portion of Medicare-approved amounts* Remainder of Medicare-approved amounts	 $0 Generally 80%	 $0 Generally 20%	 (Part B Deductible) $0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs

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

PLAN D

PARTS A & B

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

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

PLAN D

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

PLAN F

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

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

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

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

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

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: First portion of Medicare-approved amounts* Remainder of Medicare-approved amounts	 $0 Generally 80%	 (Part B Deductible) Generally 20%	 $0 $0
Part B Excess Charges (Above Medicare-approved amounts)	$0	100%	$0
BLOOD First 3 pints Next portion of Medicare-approved amounts* Remainder of Medicare-approved amounts	$0 $0 80%	All costs (Part B Deductible) 20%	$0 $0 $0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN F

PARTS A & B

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

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

PLAN F

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

HIGH DEDUCTIBLE BENEFIT PLAN F

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

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

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

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

**** The High Deductible Benefit Plan F pays the same benefits as the Standardized Benefit Plan F after one has paid a calendar year deductible. The annual deductible for the High Deductible Benefit Plan F is subject to change. For the current deductible, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. Benefits from the High Deductible Benefit Plan F will not begin until out-of-pocket expenses are equal to the calendar year deductible. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes, without limitation, the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

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

HIGH DEDUCTIBLE BENEFIT PLAN F

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

* Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year. The Part B Deductible will be applied toward the annual deductible for the calendar year set forth in NAC 687B.311.

** The High Deductible Benefit Plan F pays the same benefits as the Standardized Benefit Plan F after one has paid a calendar year deductible. The annual deductible for the High Deductible Benefit Plan F is subject to change. For the current deductible, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. Benefits from the High Deductible Benefit Plan F will not begin until out-of-pocket expenses are equal to the calendar year deductible. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes, without limitation, the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY THE DEDUCTIBLE PLAN PAYS **	IN ADDITION TO THE DEDUCTIBLE YOU PAY **
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: First portion of Medicare-approved amounts* Remainder of Medicare-approved amounts	 $0 Generally 80%	 (Part B Deductible) Generally 20%	 $0 $0
Part B Excess Charges (Above Medicare-approved amounts)	$0	100%	$0

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

HIGH DEDUCTIBLE BENEFIT PLAN F

MEDICARE (PARTS A & B)

* Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year. The Part B Deductible will be applied toward the annual deductible for the calendar year set forth in NAC 687B.311.

** The High Deductible Benefit Plan F pays the same benefits as the Standardized Benefit Plan F after one has paid a calendar year deductible. The annual deductible for the High Deductible Benefit Plan F is subject to change. For the current deductible, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. Benefits from the High Deductible Benefit Plan F will not begin until out-of-pocket expenses are equal to the calendar year deductible. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes, without limitation, the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

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

HIGH DEDUCTIBLE BENEFIT PLAN F

OTHER BENEFITS - NOT COVERED BY MEDICARE

* The High Deductible Benefit Plan F pays the same benefits as the Standardized Benefit Plan F after one has paid a calendar year deductible. The annual deductible for the High Deductible Benefit Plan F is subject to change. For the current deductible, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. Benefits from the High Deductible Benefit Plan F will not begin until out-of-pocket expenses are equal to the calendar year deductible. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes, without limitation, the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

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

PLAN G

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

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

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

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

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

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First portion of Medicare-approved amounts*	$0	$0	(Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next portion of Medicare-approved amounts*	$0	$0	(Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN G

PARTS A & B

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

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

PLAN G

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

PLAN K

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

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

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

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

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

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

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

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

PLAN K

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

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

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First portion of Medicare-approved amounts ****	$0	$0	(Part B Deductible) ****◆
Preventive Benefits for Medicare-covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10%◆
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit)
BLOOD			
First 3 pints	$0	50%	50%◆
Next portion of Medicare-approved amounts ****	$0	$0	(Part B Deductible) ****◆
Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10%◆
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN K

PARTS A & B

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

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

***** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

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

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

PLAN L

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

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

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

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

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

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co[-]payment/coinsurance for outpatient drugs and inpatient respite care	75% of copayment/coinsurance	25% of copayment[s]/coinsurance ◆

PLAN L

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

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

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

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

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY *
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First portion of Medicare-approved amounts ****	$0	$0	(Part B Deductible) ****◆
Preventive Benefits for Medicare-covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%◆
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit)*
BLOOD			
First 3 pints	$0	75%	25%◆
Next portion of Medicare-approved amounts ****	$0	$0	(Part B Deductible) ◆
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%◆
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN L

PARTS A & B

~~[***** 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.]~~

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

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

***** Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY *
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment:			
First portion of Medicare-approved amounts *****	$0	$0	(Part B Deductible) ◆
Remainder of Medicare-approved amounts	80%	15%	5%◆

PLAN M

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

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

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

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

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

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

PLAN M

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: First portion of Medicare-approved amounts* Remainder of Medicare-approved amounts	 $0 Generally 80%	 $0 Generally 20%	 (Part B Deductible) $0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD First 3 pints Next portion of Medicare-approved amounts* Remainder of Medicare-approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 (Part B Deductible) $0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN M

PARTS A & B

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

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

PLAN M

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

PLAN N

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

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

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

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

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

PLAN N

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: First portion of Medicare-approved amounts* Remainder of Medicare-approved amounts	 $0 Generally 80%	 $0 Balance, other than up to ** per office visit and up to ** per emergency room visit. The copayment of up to ** is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	 (Part B Deductible) Up to ** per office visit and up to ** per emergency room visit. The copayment of up to ** is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD First 3 pints Next portion of Medicare-approved amounts* Remainder of Medicare-approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 (Part B Deductible) $0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

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

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

PLAN N

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

11. Paragraph (h) of subsection 2 of section 15 has been amended to read as follows:

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

To the best of your knowledge,

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

Yes _____ No _____

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

Yes _____ No _____

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

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

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

Yes _____ No _____

If yes,

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

Yes _____ No _____

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

Yes _____ No _____

(3) (a) If you had coverage from any Medicare plan other than the original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO

or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "End" blank.

Start ___/___/___ End ___/___/___

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

Yes _____ No _____

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

Yes _____ No _____

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

Yes _____ No _____

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

Yes _____ No _____

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

_____

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

Yes _____ No _____

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

Yes _____ No _____

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

_____

_____

_____

_____

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

Start ___/___/___ End ___/___/___

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

After considering the record and the recommendations of the Hearing Officer, the Commissioner has issued an order adopting the proposed permanent regulation, LCB File No. R049-09, as amended, as a permanent regulation of the Division.

The economic impact of the regulation is as follows:

(a) On the business it is to regulate: The industry will incur additional cost to file new rates and forms based on the new federal requirements of GINA and MIPPA.

(b) On Small Business: The proposed regulation should have no economic impact on small business. The regulation amends Chapter 687B of the NAC and LCB File No. R049-09 to comply with the federal requirements of GINA and MIPPA.

(c) On the public: The proposed regulation will have no economic impact on the public.

There should be only minimal cost to the Division to review forms and rates updated to comply with the permanent regulation. Although, the Division is not aware of any overlap or duplication of the permanent regulation with any state or local regulation, the regulation is intended to comply with the federal requirements of MIPPA and GINA as reflected in those federal acts.

Very truly yours,

_____/s/_____
SCOTT J. KIPPER
Commissioner of Insurance

c: Brenda Erdoes, Legislative Counsel
Sherri LeTourneau, Division of Insurance
Van Mouradian, Chief, Life and Health Section, Division of Insurance

STATE OF NEVADA
DEPARTMENT OF BUSINESS AND INDUSTRY
DIVISION OF INSURANCE

IN THE MATTER OF THE

CAUSE NO. **09.0368**
LCB FILE NO. **R049-09**

PERMANENT REGULATION REGARDING MEDICARE SUPPLEMENT POLICIES.

SUMMARY OF PROCEEDINGS AND ORDER

_____/

SUMMARY OF PROCEEDINGS

A public workshop, as required by Nevada Revised Statues ("NRS") 233B.061, on the proposed permanent regulation concerning Medicare supplement insurance policies was held before Amy L. Parks, Esq., Hearing Officer, on October 14, 2009, in Carson City, Nevada, and video-conferenced to the Bradley Building in Las Vegas, Nevada. A public hearing on the proposed permanent regulation was also held before the Hearing Officer on October 21, 2009, in Carson City, Nevada, and video-conferenced to the Bradley Building in Las Vegas, Nevada. The regulation is proposed under the authority of NRS 679B.130, 687B.120 and 687B.430.

The Department of Business and Industry, Division of Insurance ("Division"), received written comments from Leanne Gassaway of America's Health Insurance Plans ("AHIP"). The workshop was attended by 12 interested parties in Carson City and 3 interested parties in Las Vegas. The hearing was attended by 10 interested parties in Carson City and 2 interested parties in Las Vegas. The following person provided testimony before the Hearing Officer: Jack Childress, representing the Division.

Mr. Childress testified that the proposed, permanent regulation amends Legislative Counsel Bureau's ("LCB") File No. R049-09 to include changes authorized by the Medicare Improvements for Patients and Providers Act of 2008 ("MIPPA") and the Genetic Information Nondiscrimination Act of 2008 ("GINA"). The amended sections update the

current regulation to be in compliance with federal law and apply to all life and health insurers marketing Medigap policies in this state.

Based upon the written comments and testimony received at the hearing, the changes to the proposed permanent regulation[2] are as indicated in Exhibit "A", attached hereto.

RECOMMENDED ORDER OF THE HEARING OFFICER

Based upon the testimony received at the hearing, it is recommended that the proposed permanent regulation concerning Medicare Supplement Policies, LCB File No. R049-09, be adopted, as amended, as a permanent regulation of the Division.

SO RECOMMENDED this 21st day of October, 2009.

/s/
AMY L. PARKS, ESQ.
Hearing Officer

ORDER OF THE COMMISSIONER

Having reviewed the record in this matter and the recommendation of the Hearing Officer, it is hereby ordered that the proposed, permanent regulation regarding Medicare Supplement Policies, LCB File No. R049-09, be adopted, as amended, as a permanent regulation of the Division.

SO ORDERED this 21st day of October, 2009.

/s/
SCOTT J. KIPPER
Commissioner of Insurance

[2] The changes shown in the Summary of Proceedings include: 1) the revised changes made after the workshop which were incorporated into the LCB Draft of Revised Proposed Regulation R049-09 received by the Division of Insurance on October 19, 2009 ("LCB Draft"); and 2) the five changes to the LCB Draft as testified to by Jack Childress in the Hearing held on October 21, 2009. Any prior changes to the Proposed Permanent Regulation R049-09 are not included in this Summary.