LCB File No. 110-98

NOTICE OF WORKSHOPS TO SOLICIT COMMENTS ON PROPOSED REGULATIONS

September 2, 1998

The Department of Business and Industry, Division of Insurance (Division) is proposing the amendment of regulations pertaining to chapters 616B, 687B, 695F, and 697 of the Nevada Administrative Code. A workshop has been set for 10:00 a.m., on September 24, 1998, at the offices of the Division, 1665 Hot Springs Road, Suite 152, Carson City, Nevada. The purpose of the workshop is to solicit comments from interested persons on the following general topics addressed in the proposed regulations.

1. **Amendments to chapter 616B of NAC. The proposed regulation:**
   (a) Prescribes the basic policy of insurance to be used by private carriers for workers compensation insurance; and
   (b) Provides for the qualification of groups for workers compensation insurance.

2. **Amendments to chapter 687B of NAC. The proposed regulation amends the provisions relating to Medicare Supplement insurance and recognizes the federal changes concerning the Medicare+Choice program.**

3. **Amendments to chapter 695F of NAC. The proposed regulation provides for the licensure of Provider-Sponsored Organizations.**

4. **Amendments to chapter 697 of NAC. The proposed regulation prohibits the advertisement or solicitation of bail in or about a court, prison, jail, or detention facility.**

A copy of this notice and the proposed regulation will be on file at the State Library, 100 Stewart Street, Carson City, Nevada, for inspection by members of the public during business hours. Additional copies of the notice and the regulation to be amended will be available at the offices of the Division, 1665 Hot Springs Road, Suite 152, Carson City, Nevada 89706, and 2501 East Sahara Avenue, Suite 302, Las Vegas, Nevada 89104, and in all counties in which an office of the agency is not maintained, at the main public library, for inspection and copying by members of the public during business hours. This notice and the text of the proposed regulation are also available in the State of Nevada Register of Administrative Regulations which is prepared and published monthly by the Legislative Counsel Bureau pursuant to NRS 233B.0653 and on the Internet at http://www.leg.state.nv.us. Copies will also be mailed to members of the public upon request. A reasonable fee may be charged for copies if it is deemed necessary.

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

Department of Business and Industry
Division of Insurance
1665 Hot Springs Road, Suite 152
Carson City, NV 89706

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

Legislative Counsel Bureau
Capitol Complex
Carson City, NV 89710

Blasdel Building
Capitol Complex
Carson City, NV 89710

State Capitol
Capitol Complex
Carson City, NV 89710

Capitol Press Room
State Capitol Basement
Carson City, NV 89710

County Clerk
Courthouse
Carson City, NV 89710

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

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

Churchill County Library
553 South Maine Street
Fallon, NV 89406

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

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

Elko County Library
720 Court Street
Elko, NV 89801

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

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

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

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

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

Lyon County Library
20 Nevin Way
Yerington, NV 89447

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

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

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

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

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

White Pine County Library
950 Campton Street
Ely, NV 89301

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

Members of the public who are disabled and require special accommodations or assistance at the hearing are requested to notify the Commissioner's secretary in writing at 1665 Hot Springs Road, Suite 152, Carson City, Nevada 89706, or by calling no later than 5 working days prior to the hearing, (702) 687-4270.

DATED this _____ day of _____, 19____.

_____
ALICE A. MOLASKY-ARMAN
Commissioner of Insurance

LCB File No. 110-98

NOTICE OF INTENT TO ACT UPON A REGULATION

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

The Department of Business and Industry, Division of Insurance (Division) will hold a public hearing at 10:00 a.m., on October 7, 1998, at the offices of the Division, 1665 Hot Springs Road, Suite 152, Carson City, Nevada. The purpose of the hearing is to receive comments from all interested persons regarding the amendment of regulations pertaining to chapter 687B of the Nevada Administrative Code.

REGULATIONS CONCERNING POLICIES OF INSURANCE TO SUPPLEMENT MEDICARE

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

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

2. The regulation adds two new high deductible plans, expands provisions for open enrollment, establishes provisions for guaranteed issue coverage under certain situations, and recognizes the Medicare+Choice program.

3. Estimated economic effect of the regulation:
   On the business which it is to regulate:
   The regulation may have both a short-term and long-term financial impact on insurers due to the provisions requiring open enrollment and guaranteed issue which limits underwriting and preexisting conditions.
   On the public:
   The amended regulation should have no economic impact on the public.

4. The Division anticipates a nominal expense to enforce the proposed regulation.

5. The regulation dovetails with changes in federal requirements and guidelines for medicare supplement policies. The federal regulatory agency responsible for Medicare and establishing standards for medicare supplement policies is the Department of Health and Human Services, Health Care Financing Administration.

6. The regulation is based on the Social Security Act, which covers social security, medicare, and in this case, standards for medicare supplement insurance policies.

7. There are no provisions in the regulation which are more stringent than the federal regulation which regulates the same activity.

8. The proposed regulation does not establish a new fee or increase an existing fee.

Persons wishing to comment upon the proposed action of the Division may appear at the scheduled public hearing or may address their comments, data, views or arguments, in written form, to the Division, 1665 Hot Springs Road, Suite 152, Carson City, Nevada 89706. Written submissions

must be received by the Division on or before October 1, 1998. If no person who is directly affected by the proposed action appears to request time to make an oral presentation, the Division may proceed immediately to act upon any written submissions.

A copy of this notice and the proposed regulation will be on file at the State Library, 100 Stewart Street, Carson City, Nevada, for inspection by members of the public during business hours. Additional copies of the notice and the regulation to be amended will be available at the offices of the Division, 1665 Hot Springs Road, Suite 152, Carson City, Nevada 89706, and 2501 East Sahara Avenue, Suite 302, Las Vegas, Nevada 89104, and in all counties in which an office of the agency is not maintained, at the main public library, for inspection and copying by members of the public during business hours. This notice and the text of the proposed regulation are also available in the State of Nevada Register of Administrative Regulations which is prepared and published monthly by the Legislative Counsel Bureau pursuant to NRS 233B.0653 and on the Internet at http://www.leg.state.nv.us. Copies will also be mailed to members of the public upon request. A reasonable fee may be charged for copies if it is deemed necessary.

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

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

Department of Business and Industry
Division of Insurance
1665 Hot Springs Road, Suite 152
Carson City, NV 89706

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

Legislative Counsel Bureau
Capitol Complex
Carson City, NV 89710

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Las Vegas Library
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Douglas County Library
1625 Library Lane
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Minden, NV 89423

Elko County Library
720 Court Street
Elko, NV 89801

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

Goldfield, NV 89013

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

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

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

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

Lyon County Library
20 Nevin Way
Yerington, NV 89447

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

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Reno, NV 89505

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950 Campton Street
Ely, NV 89301

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

Members of the public who are disabled and require special accommodations or assistance at the hearing are requested to notify the Commissioner's secretary in writing at 1665 Hot Springs Road, Suite 152, Carson City, Nevada 89706, or by calling no later than 5 working days prior to the hearing, (702) 687-4270.

DATED this _____ day of September, 1998.

ALICE A. MOLASKY-ARMAN
Commissioner of Insurance

PROPOSED REGULATION OF THE DIVISION OF INSURANCE

REGULATIONS CONCERNING
POLICIES OF INSURANCE
TO SUPPLEMENT MEDICARE

Authority: NRS 679B.130.

Section 1. Chapter 687B of NAC is amended by adding thereto the provisions set forth in sections 2 to 5 of this regulation.

Sec. 2.

1. Eligible persons are those individuals described in Section 3 who apply to enroll under the policy not later than sixty-three (63) days after the date of the termination of enrollment described in Section 3, and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement policy.

2. With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in Section 4 that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

Sec. 3 An eligible person is an individual described in any of the following paragraphs:

1. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual:

2. The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under part C of Medicare, and there are circumstances permitting

discontinuance of the individual's election of the plan under the first sentence of Section 1851(e)(4) of the federal Social Security Act:

3. The individual is enrolled with:

(a) An eligible organization under a contract under Section 1876 (Medicare risk or cost):

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

(c) An organization under an agreement under Section 1833(a)(1)(A)(health care prepayment plan): or

(d) An organization under a Medicare Select policy; and

(e) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under the first sentence of Section 1851(e)(4) of the federal Social Security Act:

4. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

(a) Of the insolvency of the issuer or bankruptcy of the nonissuer organization: or

(b) Of other involuntary termination of coverage or enrollment under the policy:

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

(d) The issuer or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual:

5. The individual was enrolled under a medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare+Choice organization under a Medicare+Choice plan under part C of Medicare, any eligible organization under a

contract under Section 1876 (Medicare risk or cost), any similar organization operating under demonstration project authority, an organization under an agreement under section 1833(a)(a)(A)(health care prepayment plan), or a Medicare Select policy; and

the subsequent enrollment under subparagraph (a) is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the federal Social Security Act); or

6. The individual upon first becoming eligible for benefits under part A of Medicare at age 65, enrolls in a Medicare+Choice plan under part C of Medicare, and disenrolls from the plan by not later than twelve (12) months after the effective date of enrollment.

Sec. 4. The medicare supplement policy to which eligible persons are entitled under:

1. Section 3, subsections 1, 2, 3, and 4 is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, or F offered by any issuer.

2. Section 3, subsection 5 is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available , a policy described in subsection 1.

3. Section 3, subsection 6 shall include any Medicare supplement policy offered by any issuer.

Sec. 5.

1. At the time of an event described in Section 3 because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her

rights under this section, and of the obligations of issuers of Medicare supplement policies under Section 2. Such notice shall be communicated contemporaneously with the notification of termination.

2. At the time of an event described in Section 3 because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment the issuer offering the policy, or the administration of the plan, respectively, will notify the individual of his or her rights under this section and of the obligations of issuers of Medicare supplement policies under Section 2. Such notice shall be communicated within ten (10) working days of the issuer receiving notification of disenrollment.

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

As used in NAC 687B.200 to 687B.330, inclusive, unless the context otherwise requires:

1. "Applicant" means:

(a) In the case of an individual policy to supplement Medicare, the person who seeks to contract for insurance benefits.

(b) In the case of a group policy to supplement Medicare, the proposed certificate holder.

2. "Bankruptcy" means when a Medicare+Choice organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

[2.] 3. "Certificate" means any certificate delivered or issued for delivery in this state under a group policy to supplement Medicare.

[3.] 4. "Certificate form" means the form on which a certificate is delivered or issued for delivery by the issuer.

5. “Continuous period of creditable coverage” means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days.

6. “Creditable coverage” means health benefits or coverage provided to a person pursuant to:

(a) A group health plan;

(b) A health benefit plan;

(c) Part A or Part B of Title XVIII of the Social Security Act, also known as Medicare;

(d) Title XIX of the Social Security Act, also known as Medicaid, other than coverage consisting solely of benefits under section 1928 of that Title;

(e) Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of Uniformed Services (CHAMPUS));

(f) A medical care program of the Indian Health Service or of a tribal organization;

(g) A state health benefit risk pool;

(h) A health plan offered pursuant to chapter 89 of Title 5, United States Code (Federal Employees Health Benefits Program (FEHBP));

(i) A public health plan as defined in federal regulations authorized by the Public Health Service Act, section 2701(c)(1)(I),* as amended by Public Law 104-191; or

(j) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. § 2504(e)).

* 42 U.S.C. 300gg(c)(1)(I).

7. “Employee welfare benefit plan” means a plan, fund or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act).

8. "Group health plan" means an employee welfare benefit plan, as defined in section 3(1) of the Employee Retirement Income Security Act of 1974, as that section existed on July 16, 1997, to the extent that the plan provides medical care to employees or their dependents as defined under the terms of the plan directly, or through insurance, reimbursement or otherwise.

(a) The term does not include:

(1) Coverage that is only for accident or disability income insurance, or any combination thereof;

(2) Coverage issued as a supplement to liability insurance;

(3) Liability insurance, including general liability insurance and automobile liability insurance;

(4) Workers' compensation or similar insurance;

(5) Coverage for medical payments under a policy of automobile insurance;

(6) Credit insurance;

(7) Coverage for on-site medical clinics; and

(8) Other similar insurance coverage specified in federal regulations issued pursuant to Public Law 104-191 under which benefits for medical care are secondary or incidental to other insurance benefits.

(b) The term does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of a health benefit plan:

(1) Limited-scope dental or vision benefits;

(2) Benefits for long-term care, nursing home care, home health care or community-based care, or any combination thereof; and

(3) Such other similar benefits as are specified in any federal regulations adopted pursuant to Public Law 104-191.

(c) The term does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and such benefits are paid for a claim without regard to whether benefits are provided for such a claim under any group health plan maintained by the same plan sponsor:

(1) Coverage that is only for a specified disease or illness; and

(2) Hospital indemnity or other fixed indemnity insurance.

(d) The term does not include any of the following, if offered as a separate policy, certificate or contract of insurance:

(1) Medicare supplemental health insurance as defined in section 1882(g)(1) of the Social Security Act, as that section existed on the effective date of this act;

(2) Coverage supplemental to the coverage provided pursuant to chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of Uniformed Services (CHAMPUS)); and

(3) Similar supplemental coverage provided under a group health plan.

9. "Insolvency" means when an issuer, licensed to transact the business of insurance in Nevada, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

[4.] 10. "Issuer" means any insurance company, fraternal benefit society, nonprofit corporation for hospital, medical and dental services or health maintenance organization offering a policy to supplement Medicare which is delivered or issued for delivery in this state.

[5.] 11. "Medicare" means the program of health insurance for aged and disabled persons established pursuant to Title XVIII of the Social Security Act (42 U.S.C.§§1395 et seq).

12. "Medicare+Choice plan" means a plan of coverage for health benefits under Medicare Part C as defined in Section 1859 of Title IV, Subtitle A, chapter 1 of P.L. 105-331, and includes:

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

(b) Medical savings account plans coupled with a contribution into a Medicare+Choice medical savings account; and

(c) Medicare+Choice private fee-for-service plans.

[6.] 13. "Policy form" means the form on which a policy to supplement Medicare is delivered or issued for delivery by the issuer.

[7.] 14. "Policy to supplement Medicare" means a group or individual policy of accident and sickness insurance, or a subscriber contract, other than a policy issued pursuant to a contract under section 1876 of the Social Security Act (42 U.S.C.§1395 mm) or under a demonstration project that is advertised, marketed or designed primarily as a supplement to the reimbursements provided under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

15. "Secretary" means the Secretary of the United States Department of Health and Human Services.

Sec. 7. NAC 687B.207 is hereby amended to read as follows:

Coverage if application is submitted before or during first 6-month period in which person is both 65 years of age or older and enrolled under Medicare Part B; availability of coverage to all qualified applicants.

1. If an application for a policy to supplement Medicare or a certificate is submitted to an issuer before or during the first 6-month period in which a person is both 65 years of age or older and is enrolled for benefits under Medicare Part B, the issuer may not deny or condition the issuance or effectiveness of the policy or certificate, or discriminate in the pricing of the policy or certificate, based on:

(a) The health status of the applicant;

(b) The applicantɔs claims experience;

(c) Receipt of health care by the applicant; or

(d) The medical condition of the applicant.

2. A policy to supplement Medicare or a certificate which is available from an issuer must be made available to all qualified applicants, regardless of age.

3. The provisions of subsections 1, 4, and 5 do not prevent the exclusion of benefits under a policy to supplement Medicare or a certificate, for the first 6 months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the 6 months before the policy or certificate became effective.

4. If an applicant qualifies under Subsection 1 of this Section and submits an application during the time period referenced in Subsection 1 and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer shall not exclude benefits based on a preexisting condition.

5. If the applicant qualifies under Subsection 1 of this Section and submits an application during the time period referenced in Subsection 1 and, as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary shall specify the manner of the reduction under this subsection.

Sec. 8. NAC 687B.250 is hereby 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 certificate is issued on a basis that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered. The substitute outline must contain the following statement, in not less than 12-point type, immediately above the name of the company: NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued.

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

(a) A cover page;

(b) Information regarding premiums;

(c) Disclosure pages; and

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

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

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

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

(COMPANY NAME)

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

Medicare supplement insurance can be sold in only ten standard plans plus two high deductible plans. This chart shows the benefits included in each plan. Every company must make available Plan ✌A✍. Some plans may not be available in your state.

Basic Benefits: Included in All Plans
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (20% of Medicare-approved expenses).
Blood: First three pints of blood each year.

A	B	C	D	E	F | F*	G	H	I	J | J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Coinsur-ance	Skilled Nursing Coinsur-ance	Skilled Nursing Coinsur-ance	Skilled Nursing Coinsur-ance	Skilled Nursing Coinsur-ance	Skilled Nursing Coinsur-ance	Skilled Nursing Coinsur-ance	Skilled Nursing Coinsur-ance
	Part A Deducti-ble	Part A Deducti-ble	Part A Deducti-ble	Part A Deducti-ble	Part A Deducti-ble	Part A Deducti-ble	Part A Deducti-ble	Part A Deducti-ble	Part A Deducti-ble
		Part B Deducti-ble			Part B Deducti-ble				Part B Deducti-ble
					Part B Excess 100%	Part B Excess 80%		Part B Excess 100%	Part B Excess 100%
		Foreign Travel Emer-gency	Foreign Travel Emer-gency	Foreign Travel Emer-gency	Foreign Travel Emer-gency	Foreign Travel Emer-gency	Foreign Travel Emer-gency	Foreign Travel Emer-gency	Foreign Travel Emer-gency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
							Basic Drugs ($1,250 Limit)	Basic Drugs ($1,250 Limit)	Basic Drugs ($3,000 Limit)
				Preven-tive Care					Preven-tive Care

* Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year $1,500 deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses are $1,500. 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 does not include, in Plan J, the plan's separate prescription drug deductible or in Plans F and J, the plan's separate foreign travel emergency deductible.

PREMIUM INFORMATION (Boldface type)

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

DISCLOSURES (Boldface type)

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY (Boldface type)

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

RIGHT TO RETURN POLICY (Boldface type)

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

POLICY REPLACEMENT (Boldface type)

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

NOTICE (Boldface type)

This policy may not cover all of your medical costs.

(For agents)

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

(For direct response)

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT
(Boldface type)

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

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

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

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$628] $764	$0	[$628] $764 (Part A Deductible)
61st thru 90th day	All but [$157] $191 a day	[$157] $191 a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but [$314] $382 a day	[$314] $382 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 [$78.50] $95.50 a day	$0	Up to [$78.50] $95.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

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

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

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

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$628] $764	[$628] $764 (Part A Deductible)	$0
61st thru 90th day	All but [$157] $191 a day	[$157] $191 a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but [$314] $382 a day	[$314] $382 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 [$78.50] $95.50 a day	$0	Up to [$78.50] $95.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN B

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$628] $764	[$628] $764 (Part A Deductible)	$0
61st thru 90th day	All but [$157] $191 a day	[$157] $191 a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but [$314] $382 a day	[$314] $382 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 [$78.50] $95.50 a day	Up to [$78.50] $95.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN C

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

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

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

PLAN C

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$628] $764	[$628] $764 (Part A Deductible)	$0
61st thru 90th day	All but [$157] $191 a day	[$157] $191 a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but [$314] $382 a day	[$314] $382 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 [$78.50] $95.50 a day	Up to [$78.50] $95.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN D

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

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

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

PLAN D

MEDICARE (PARTS A & B) - (CONTINUED)

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

PLAN E

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$628] $764	[$628] $764 (Part A Deductible)	$0
61st thru 90th day	All but [$157] $191 a day	[$157] $191 a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but [$314] $382 a day	[$314] $382 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 [$78.50] $95.50 a day	Up to [$78.50] $95.50 a day	$0
101st day and after	$0	$0	[$0] All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN E

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

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

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

PLAN E

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

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

PLAN F or HIGH DEDUCTIBLE PLAN F

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

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

** This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year $1,500 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $1,500. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes 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 $1,500 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $1,500 DEDUCTIBLE** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$628] $764	[$628] $764 (Part A Deductible)	$0
61st thru 90th day	All but [$157] $191 a day	[$157] $191 a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but [$314] $382 a day	[$314] $382 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 [$78.50] $95.50 a day	Up to [$78.50] $95.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN F or HIGH DEDUCTIBLE PLAN F

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

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

** This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year $1,500 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $1,500. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes 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 $1,500 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $1,500 DEDUCTIBLE** YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First $100 of Medicare-approved amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare-approved amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
	PARTS A & B		
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
---Medically necessary skilled care services and medical supplies	100%	$0	$0
---Durable medical equipment: First $100 of Medicare-approved amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	

PLAN F or HIGH DEDUCTIBLE PLAN F

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1,500 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $1,500 DEDUCTIBLE** YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States:			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$628] $764	[$628] $764 (Part A Deductible)	$0
61st thru 90th day	All but [$157] $191 a day	[$157] $191 a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but [$314] $382 a day	[$314] $382 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 [$78.50] $95.50 a day	Up to [$78.50] $95.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN G

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

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

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

PLAN G

MEDICARE (PARTS A & B) - (CONTINUED)

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

PLAN H

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$628] $764	[$628] $764 (Part A Deductible)	$0
61st thru 90th day	All but [$157] $191 a day	[$157] $191 a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but [$314] $382 a day	[$314] $382 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 [$78.50] $95.50 a day	Up to [$78.50] $95.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN H

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

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

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

PLAN H

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

PLAN I

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$628] $764	[$628] $764 (Part A Deductible)	$0
61st thru 90th day	All but [$157] $191 a day	[$157] $191 a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but [$314] $382 a day	[$314] $382 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 [$78.50] $95.50 a day	Up to [$78.50] $95.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN I

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

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

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

PLAN I

MEDICARE (PARTS A & B) - (CONTINUED)

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

PLAN J or HIGH DEDUCTIBLE 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 days in a row.

** This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year $1,500 deductible. Benefits from the high deductible Plan J will not begin until out-of-pocket expenses are $1,500. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes 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 $1,500 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $1,500 DEDUCTIBLE** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$628] $764	[$628] $764 (Part A Deductible)	$0
61st thru 90th day	All but [$157] $191 a day	[$157] $191 a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but [$314] $382 a day	[$314] $382 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 [$78.50] $95.50 a day	Up to [$78.50] $95.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN J or HIGH DEDUCTIBLE PLAN J

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

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

** This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year $1,500 deductible. Benefits from the high deductible Plan J will not begin until out-of-pocket expenses are $1,500. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes 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 $1,500 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $1,500 DEDUCTIBLE** YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First $100 of Medicare-approved amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare-approved amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
	PARTS A & B		
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
---Medically necessary skilled care services and medical supplies	100%	$0	$0
---Durable medical equipment: First $100 of Medicare-approved amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

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

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

PLAN J or HIGH DEDUCTIBLE PLAN J

OTHER BENEFITS - (CONTINUED)

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

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

Sec. 9. NAC 687B.308 is hereby amended to read as follows:

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

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

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

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

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

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

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

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

(1) A [fecal occult blood test or] digital rectal examination[, or both].

[(2) A mammogram.]

[(3)] (2) A dipstick urinalysis for hematuria, bacteriuria and proteinuria.

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

[(5)] (4) A serum cholesterol screening every 5 years.

[(6)] (5) A thyroid function test.

[(7)] (6) A screening for diabetes.

(c) A [vaccination for influenza administered at any appropriate time during the year and a] vaccination for tetanus and diphtheria administered every 10 years.

(d) Any other tests or preventative measures deemed appropriate by the attending physician.

Sec. 10. NAC 687B.311 is hereby amended to read as follows:

A benefit plan to supplement Medicare which is designated as Standardized Benefit Plan F 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 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.

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. A benefit plan to supplement Medicare which is designated as High Deductible Plan F must include only the following: 100% of covered expenses following the payment of the annual High Deductible Plan F deductible. The covered expenses must include the core benefit as defined in Section 290 of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in subsections 2, 3, 4, 5 and 6, respectively. The annual High Deductible Plan F deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan ✌F✍ policy, and shall be in addition to any other specific benefit deductibles. The annual High Deductible Plan F deductible shall be $1,500 for

1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

Sec. 11. NAC 687B.319 is hereby amended to read as follows:

A benefit plan to supplement Medicare which is designated as Standardized Benefit Plan J 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 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.

6. As an extended benefit, coverage 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.

7. 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.

8. 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 Associationэs Current Procedural Terminology (AMA CPT) codes, not to exceed $120 per year, to the extent not covered by Medicare:

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

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

(1) A [fecal occult blood test or] digital rectal examination[, or both].

[(2) A mammogram.]

[(3)] (2) A dipstick urinalysis for hematuria, bacteriuria and proteinuria.

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

[(5)] (4) A serum cholesterol screening every 5 years.

[(6)] (5) A thyroid function test.

[(7)] (6) A screening for diabetes.

(c) A [vaccination for influenza administered at any appropriate time during the year and a] vaccination for tetanus and diphtheria administered every 10 years.

(d) Any other tests or preventative measures deemed appropriate by the attending physician.

9. 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.

10. A benefit plan to supplement Medicare which is designated as High Deductible Plan J must include only the following: 100% of covered expenses following the payment of the annual High Deductible Plan J deductible. The covered expenses must include the core benefit as defined in Section 290 of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in subsections 2, 3, 4, 5, 6, 7, 8 and 9, respectively. The annual High Deductible Plan J deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan ✌J✍ policy, and shall be in addition to any other specific benefit deductibles. The annual High Deductible Plan J deductible shall be $1,500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the

preceding year, and rounded to the nearest multiple of $10. deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan ✌J✍ policy, and shall be in addition to any other specific benefit deductibles. The annual High Deductible Plan J deductible shall be $1,500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

Sec. 12. NAC 687B.705, 687B.710 AND 687B.715 are hereby repealed.