PROPOSED REGULATION OF THE

COMMISSIONER OF INSURANCE

LCB File No. R110-98

October 6, 1998

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

AUTHORITY: §§2-27, NRS 679B.130 and NRS 687B.430.

Section 1. Chapter 687B of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 17, inclusive, of this regulation.

Sec. 2. *"Applicant" means:*

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

2. In the case of a group policy to supplement Medicare, the proposed certificate holder.

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

Sec. 4. *"Eligible organization" has the meaning ascribed to it in section 1876(b) of the Social Security Act, 42 U.S.C. § 1395mm(b).*

Sec. 5. *"Employee welfare benefit plan" has the meaning ascribed to it in section 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(1).*

Sec. 6. *"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.*

Sec. 7. *"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.*

Sec. 8. *"Medicare + Choice organization" has the meaning ascribed to it in section 1859(a)(1) of the Social Security Act, 42 U.S.C. § 1395w-28(a)(1).*

Sec. 9. *"Medicare + Choice plan" means a plan of health insurance established by the program set forth in sections 1851 to 1859, inclusive, of the Social Security Act, 42 U.S.C. §§ 1395w-21 to -28, inclusive.*

Sec. 10. *"Medicare select issuer" has the meaning ascribed to it in NAC 687B.346.*

Sec. 11. *"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 section 1876 of the Social Security Act, 42 U.S.C. § 1395mm, or pursuant to 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.*

Sec. 12. *"Standardized benefit plan" means a benefit plan to supplement Medicare that is designated as Standardized Benefit Plan A through J, inclusive, or High Deductible Benefit Plan F or J, as set forth in NAC 687B.300 to 687B.319.*

Sec. 13. *1. A person is eligible for a policy to supplement Medicare that is offered to new enrollees or for a certificate that is offered to new enrollees if he provides evidence that he disenrolled within the previous 63 days from:*

(a) An employee welfare benefit plan that:

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

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

(b) An employee welfare benefit plan that:

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

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

(c) A Medicare + Choice plan offered by a Medicare + Choice organization pursuant to Medicare Part C, if the person was allowed to disenroll from the Medicare + Choice plan under any of the following circumstances:

(1) The certification of the Medicare + Choice organization or the Medicare + Choice plan was terminated or the Medicare + Choice organization discontinued offering the Medicare + Choice plan in the area where the person resided.

(2) The person was no longer eligible to elect a Medicare + Choice plan because:

(I) His residence changed;

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

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

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

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

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

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

(d) If the person disenrolled pursuant to the same circumstances that are required to disenroll from a plan pursuant to paragraph (c) of subsection 1 of section 13 of this regulation, any plan offered by:

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

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

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

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

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

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

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

(3) The insurer involuntarily terminated coverage or enrollment;

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

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

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

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

Sec. 14. *1. A person is eligible for a policy to supplement Medicare that is offered to new enrollees or for a certificate that is offered to new enrollees if he provides evidence that he:*

(a) Disenrolled from such a policy or certificate;

(b) Subsequently enrolled for the first time in:

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

(2) A plan offered by an eligible organization, insurer or a Medicare select issuer listed in paragraph (d) of subsection 1 of section 13 of this regulation; and

(c) Disenrolled within the previous 63 days from the subsequent plan within 12 months after his enrollment as authorized pursuant to section 1851(e) of the Social Security Act, 42 U.S.C. § 1395w-21(e).

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

Sec. 15. *1. A person is eligible for a policy to supplement Medicare that is offered to new enrollees or for a certificate that is offered to new enrollees if he provides evidence that he has disenrolled within the previous 63 days from a Medicare + Choice plan offered by a Medicare + Choice organzation pursuant to Medicare Part C if he:*

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

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

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

Sec. 16. *If an application for a policy to supplement Medicare that is offered to new enrollees or for a certificate that is offered to new enrollees is submitted to an issuer by a person who is eligible for such a policy or certificate pursuant to section 13, 14 or 15 of this regulation, the issuer shall not deny or condition the issuance or effectiveness of the policy or certificate or discriminate in the pricing of the policy or certificate on the basis of:*

1. The health status of the applicant;

2. The claims experience of the applicant;

3. The receipt of health care by the applicant;

4. The medical condition of the applicant; or

5. A preexisting condition of the applicant.

Sec. 17. *1. Any time a plan, certificate or policy to supplement Medicare is terminated or a person disenrolls from a plan, certificate, or policy to supplement Medicare, the issuer, insurer, Medicare + Choice organization, eligible organization or Medicare select issuer that offered the plan, certificate or policy shall provide written notification informing the person that:*

(a) He may be entitled to obtain a certificate or a policy to supplement Medicare pursuant to section 13, 14 or 15 of this regulation; and

(b) The issuer of such a certificate or policy must comply with the provisions of section 16 of this regulation.

2. If the plan, certificate or policy was terminated, the notification required pursuant to subsection 1 must be provided with the notification of termination. If the person disenrolled from the plan, certificate or policy, the notification required pursuant to subsection 1 must be

provided within 10 working days after the issuer, insurer, Medicare +Choice organization, eligible organization or Medicare select issuer received notification of the disenrollment.

3. As used in this section, "plan" means:

(a) A Medicare + Choice plan;

(b) An employee welfare benefit plan; or

(c) A plan offered by an eligible organization, insurer or a Medicare select issuer listed in paragraph (d) of subsection 1 of section 13 of this regulation.

Sec. 18. 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 to17, inclusive, of this regulation,* 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. "Certificate" means any certificate delivered or issued for delivery in this state under a group policy to supplement Medicare.

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

4. "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. "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.).

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

7. "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. § 1395mm) 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.**]** *, the words and terms defined in sections 2 to 12, inclusive, of this regulation have the meanings ascribed to them in those sections.*

Sec. 19. NAC 687B.205 is hereby amended to read as follows:

687B.205 1. Except as otherwise provided in NAC 687B.200 to 687B.330, inclusive, *and sections 2 to 17, inclusive, of this regulation,* the provisions of those sections apply to any:

(a) Policy to supplement Medicare delivered or issued for delivery in this state on or after July 30, 1992.

(b) Certificate.

2. The provisions of NAC 687B.200 to 687B.330, inclusive, *and sections 2 to17, inclusive, of this regulation* do not apply to any policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or any combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

Sec. 20. NAC 687B.207 is hereby amended to read as follows:

687B.207 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**]** *during* 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:**]** *on the basis of:*

(a) The health status of the applicant;

(b) The **[**applicant's**]** claims experience **[**;

(c) Receipt**]** *of the applicant;*

(c) The 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**]** *Except as otherwise provided in subsection 4, the* provisions of subsection 1 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 submits an application to an issuer in the manner set forth in subsection 1 and, as of the date on which he submits the application, the applicant has not had a break of more than 63 consecutive days in his creditable coverage and has had an aggregate period of creditable coverage for:

(a) Six months or more, the issuer shall not exclude any benefits based on a preexisting condition of the applicant; or

(b) Less than 6 months, the issuer shall use the method of reduction set forth in 45 C.F.R. § 146.111(a)(1)(iii) to reduce the period of exclusion for a preexisting condition.

5. As used in this section, "creditable coverage" has the meaning ascribed to it in NRS 689A.505.

Sec. 21. 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, *and High Deductible Benefit Plans F and J,* must be shown on the cover page and the plans offered by the issuer must be prominently identified.

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

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

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

Medicare supplement insurance **[**can**]** *may* be sold in only ten standard plans **[.]** *and two high deductible benefit 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	*High Deductible F**	G	H	I	J	*High Deductible J**
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	*Basic Benefits*	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	*Basic Benefits*
		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	*Skilled Nursing Coinsurance*	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	*Skilled Nursing Coinsurance*
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	*Part A Deductible*	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	*Part A Deductible*
		Part B Deductible			Part B Deductible	*Part B Deductible*				Part B Deductible	*Part B Deductible*
					Part B Excess (100%)	*Part B Excess (100%)*	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)	*Part B Excess (100%)*
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	*Foreign Travel Emergency*	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	*Foreign Travel Emergency*
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	*At-Home Recovery*
								Basic Drugs ($1,250 Limit)	Basic Drugs ($1,250 Limit)	Extended Drugs ($3,000 Limit)	*Extended Drugs ($3,000 Limit)*
				Preventive Care						Preventive Care	*Preventive Care*

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

PREMIUM INFORMATION (Boldface type)

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

DISCLOSURES (Boldface type)

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY (Boldface type)

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

RIGHT TO RETURN POLICY (Boldface type)

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

POLICY REPLACEMENT (Boldface type)

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

NOTICE (Boldface type)

This policy may not cover all of your medical costs.

(For agents)

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

(For direct response)

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

This outline of coverage does not give all the details of Medicare coverage. Contact your local social security office or consult "The Medicare Handbook" 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 . **[**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 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 **[**$628**]** *$764* All but **[**$157**]** *$191* a day All but **[**$314**]** *$382* a day $0 $0	 $0 **[**$157**]** *$191* a day **[**$314**]** *$382* a day 100% of Medicare Eligible Expenses $0	 **[**$628**]** *$764* (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 **[**$78.50**]** *$95.50* a day $0	 $0 $0 $0	 $0 Up to **[**$78.50**]** *$95.50* a day 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 A

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

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

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

PARTS A & B

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

PLAN B

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

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 *consecutive* days . **[**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	$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 a 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:			
First $100 of Medicare-approved amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN C

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

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 c*onsecutive* 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 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 . **[**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 outpatients drugs and inpatient respite care	$0	Balance

PLAN D

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

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

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

PARTS A & B

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

PLAN D

MEDICARE (PARTS A & B) -CONTINUED

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
PARTS A & B (cont'd)			
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 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
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 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 . **[**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 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 **[**$628**]** *$764* All but **[**$157**]** *$191* a day All but **[**$314**]** *$382* a day $0 $0	 **[**$682**]** *$764* (Part A Deductible) **[**$157**]** *$191* a day **[**$314**]** *$382* 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 **[**$78.50**]** *$95.50* a day $0	 $0 Up to **[**$78.50**]** *$95.50* a day $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 $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

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

PARTS A & B

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

PLAN E

OTHER BENEFITS -NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL-NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States: First $250 each calendar year 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 **[**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 Additional charges	 $0 $0	 $120 $0	 $0 All costs

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

PLAN F

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

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 *consecutive* days . **[**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 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 **[**$628**]** *$764* All but **[**$157**]** *$191* a day All but **[**$314**]** *$382* a day $0 $0	 **[**$628**]** *$764* (Part A Deductible) **[**$157**]** *$191* a day **[**$314**]** *$382* 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 **[**$78.50**]** *$95.50* a day $0	 $0 Up to **[**$78.50**]** *$95.50* 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	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN F

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

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

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

PARTS A & B

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

PLAN F

OTHER BENEFITS -NOT COVERED BY MEDICARE

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

HIGH DEDUCTIBLE BENEFIT PLAN F

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

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

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

SERVICES	*MEDICARE PAYS*	*AFTER YOU PAY DEDUCTIBLE PLAN PAYS***	*IN ADDITION TO DEDUCTIBLE YOU PAY***
*HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	*All but $764*	*$764 (Part A Deductible)*	*$0*
61st thru 90th day	*All but $191 a day*	*$191 a day*	*$0*
91st day and after:			
While using 60 lifetime reserve days	*All but $382 a day*	*$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 $95.50 a day*	*Up to $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*

HIGH DEDUCTIBLE BENEFIT PLAN F

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

SERVICES	*MEDICARE PAYS*	*AFTER YOU PAY DEDUCTIBLE PLAN PAYS***	*IN ADDITION TO DEDUCTIBLE YOU PAY***
HOSPICE CARE *Available as long as your doctor certifies you are terminally ill and you elect to receive these services*	*All but very limited coinsurance for outpatient drugs and inpatient respite care*	*$0*	*Balance*

HIGH DEDUCTIBLE BENEFIT PLAN F

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

** Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year. The $100 Part B Deductible will be applied toward the annual deductible for the calendar year set forth in NAC 687B.311.*

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

SERVICES	*MEDICARE PAYS*	*AFTER YOU PAY DEDUCTIBLE PLAN PAYS***	*IN ADDITION TO 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*

HIGH DEDUCTIBLE BENEFIT PLAN F

MEDICARE (PARTS A & B)

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

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* *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 . **[**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:			
First $100 of Medicare-approved amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN G

MEDICARE (PARTS A & B) -CONTINUED

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
PARTS A & B (cont'd)			
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 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
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 . **[**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 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 **[**$628**]** *$764* All but **[**$157**]** *$191* a day All but **[**$314**]** *$382* a day $0 $0	 **[**$628**]** *$764* (Part A Deductible) **[**$157**]** *$191* a day **[**$314**]** *$382* 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 **[**$78.50**]** *$95.50* a day $0	 $0 Up to **[**$78.50**]** *$95.50* 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	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN H

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

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

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

PARTS A & B

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

PLAN H

OTHER BENEFITS -NOT COVERED BY MEDICARE

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

PLAN I

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

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

PART A & B

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

PLAN I

MEDICARE (PARTS A & B) -CONTINUED

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
PARTS A & B (cont'd)			
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 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
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 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
BASIC OUTPATIENT PRESCRIPTION DRUGS-NOT COVERED BY MEDICARE First $250 each calendar year Next $2,500 each calendar year Over $2,500 each calendar year	 $0 $0 $0	 $0 50%-$1,250 calendar year maximum benefit $0	 $250 50% All costs

PLAN J

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

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 *consecutive* days . **[**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 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 **[**$628**]** *$764* All but **[**$157**]** *$191* a day All but **[**$314**]** *$382* a day $0 $0	 **[**$628**]** *$764* (Part A Deductible) **[**$157**]** *$191* a day **[**$314**]** *$382* 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 **[**$78.50**]** *$95.50* a day $0	 $0 Up to **[**$78.50**]** *$95.50* 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	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN J

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

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

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

PARTS A & B

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

PLAN J

MEDICARE (PARTS A & B) -CONTINUED

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

PLAN J

OTHER BENEFITS (cont'd)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
** PREVENTIVE MEDICAL CARE BENEFIT-NOT COVERED BY MEDICARE **[**Annual**]** *Some annual* physical and preventive tests and services such as **[**fecal occult blood test,**]** 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 Additional charges	 $0 $0	 $120 $0	 $0 All costs

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

HIGH DEDUCTIBLE BENEFIT PLAN J

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

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

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

SERVICES	*MEDICARE PAYS*	*AFTER YOU PAY DEDUCTIBLE PLAN PAYS***	*IN ADDITION TO DEDUCTIBLE YOU PAY***
*HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	*All but $764*	*$764 (Part A Deductible)*	*$0*
61st thru 90th day	*All but $191 a day*	*$191 a day*	*$0*
91st day and after:			
While using 60 lifetime reserve days	*All but $382 a day*	*$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 $95.50 a day*	*Up to $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*

HIGH DEDUCTIBLE BENEFIT PLAN J

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

SERVICES	*MEDICARE PAYS*	*AFTER YOU PAY DEDUCTIBLE PLAN PAYS***	*IN ADDITION TO DEDUCTIBLE YOU PAY***
HOSPICE CARE *Available as long as your doctor certifies you are terminally ill and you elect to receive these services*	*All but very limited coinsurance for outpatient drugs and inpatient respite care*	*$0*	*Balance*

HIGH DEDUCTIBLE BENEFIT PLAN J

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

** Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year. The $100 Part B Deductible will be applied toward the annual deductible for the calendar year set forth in NAC 687B.319.*

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

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

HIGH DEDUCTIBLE BENEFIT PLAN J

MEDICARE (PARTS A & B)

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

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* *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*
EXTENDED OUTPATIENT PRESCRIPTION DRUGS-NOT COVERED BY MEDICARE *First $250 each calendar year* *Next $6,000 each calendar year* *Over $6,000 each calendar year*	 *$0* *$0* *$0*	 *$0* *50%-$3,000 calendar year maximum benefit* *$0*	 *$250* *50%* *All costs*

HIGH DEDUCTIBLE BENEFIT PLAN J

OTHER BENEFITS (cont'd)

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

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

Sec. 22. 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, unless it complies with the provisions of NAC 687B.300 to 687B.319, inclusive.

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

(a) Have the same style, arrangement, overall content and designation as the standardized benefit plans set forth in NAC 687B.300 to 687B.319, inclusive.

(b) Conform to the definitions set forth in **[**NAC 687B.200.**]** *sections 2 to 12, inclusive, of this regulation.*

3. Each benefit must be structured in accordance with the format and listed in the order indicated in NAC 687B.300 to 687B.319, inclusive.

4. In addition to the designations for standardized benefit plans set forth in NAC 687B.300 to 687B.319, inclusive, an issuer may use other designations if he obtains the prior approval of the commissioner.

Sec. 23. NAC 687B.308 is hereby amended to read as follows:

687B.308 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 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) 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. 24. NAC 687B.311 is hereby amended to read as follows:

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

[1.**]** *(a)* The benefits required by NAC 687B.290.

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

[3.**]** *(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.

[4.**]** *(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.

[5.**]** *(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.

[6.**]** *(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 subsection, "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 benefit plan to supplement Medicare which is designated as High Deductible Benefit Plan F must require the insured to pay an annual deductible in the amount of $1,500 for the calendar years of 1998 and 1999 and in an amount that is adjusted by the Commissioner each year thereafter in the manner required pursuant to section 1882(p)(11)(C)(ii) of the Social Security Act, 42 U.S.C. § 1395ss(p)(11)(C)(ii). The deductible must be paid in addition to the premium and in addition to any other deductibles relating to a specific benefit.

Sec. 25. NAC 687B.319 is hereby amended to read as follows:

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

[1.**]** *(a)* The benefits required by NAC 687B.290.

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

[3.**]** *(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.

[4.**]** *(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.

[5.**]** *(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.

[6.**]** *(f)* 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.**]** *(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 subsection, "emergency care" means medical care needed immediately because of a sudden and unexpected injury or illness.

[8.**]** *(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:

[(a)**]** *(1)* An annual clinical medical history and physical examination that may include the tests and services set forth in **[**paragraph (b)**]** *subparagraph (2)* of this subsection and educational services that address measures to be taken for preventative health care.

[(b)**]** *(2)* 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**]**

(I) A digital rectal examination . **[**, or both.

(2) A mammogram.

(3)**]** *(II)* A dipstick urinalysis for hematuria, bacteriuria and proteinuria.

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

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

[(6)**]** *(V)* A thyroid function test.

[(7)**]** *(VI)* A screening for diabetes.

[(c)**]** *(3)* A vaccination **[**for influenza administered at any appropriate time during the year and a vaccination**]** for tetanus and diphtheria administered every 10 years.

[(d)**]** *(4)* Any other tests or preventative measures deemed appropriate by the attending physician.

[9.**]** *(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 benefit plan to supplement Medicare which is designated as High Deductible Benefit Plan J must require the insured to pay an annual deductible in the amount of $1,500 for the calendar years of 1998 and 1999 and in an amount that is adjusted by the Commissioner each year thereafter in the manner required pursuant to section 1882(p)(11)(C)(ii) of the Social Security Act, 42 U.S.C. § 1395(p)(11)(C)(ii). The deductible must be paid in addition to the premium and in addition to any other deductibles relating to a specific benefit.

Sec. 26. NAC 687B.735 is hereby amended to read as follows:

687B.735 A policy of health insurance described in NAC 687B.700, **[**687B.705, 687B.710, 687B.715,**]** 687B.720, 687B.725 or 687B.730 which provides benefits that are provided under Medicare may not be delivered or issued for delivery in this state unless the policy includes a provision that specifically states that the benefits under the policy will be provided without regard to any other policy or coverage of health insurance, including Medicare.

Sec. 27. NAC 687B.705, 687B.710, 687B.715 are hereby repealed.

TEXT OF REPEALED SECTIONS

687B.705 Notice of duplication for policy which provides benefits for nursing home care.

1. An insurer that delivers or issues for delivery in this state a policy of insurance which provides benefits for nursing home care and which provides benefits that are provided under Medicare shall provide notice to the insured that the policy contains certain benefits which are also provided under Medicare.

2. The notice must be:

(a) Printed on or attached to the first page of the application for the policy; and

(b) In not less than 12-point type and contain the following language in substantially the following form:

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

- This insurance provides benefits primarily for covered nursing home services.

- In some situations Medicare pays for short periods of skilled nursing home care and hospice care.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement Insurance.

Neither Medicare nor Medicare Supplement Insurance provides benefits for most nursing home expenses.

Before You Buy This Insurance:

- Check the coverage in **all** health insurance policies you already have.
- For more information about long-term care insurance, review "The Shopper's Guide to Long-Term Insurance," which is available from the insurance company.
- For more information about Medicare and Medicare Supplement Insurance, review "The Guide to Health Insurance for People with Medicare," which is available from the insurance company.
- For help in understanding your health insurance, contact the Commissioner of Insurance or the Nevada Medicare Information, Counseling and Assistance Program.

687B.710 Notice of duplication for policy which provides benefits for home health care only.

1. An insurer that delivers or issues for delivery in this state a policy of insurance which provides benefits for home health care only and which provides benefits that are provided under Medicare shall provide notice to the insured that the policy contains certain benefits which are also provided under Medicare.

2. The notice must be:

(a) Printed on or attached to the first page of the application for the policy; and

(b) In not less than 12-point type and contain the following language in substantially the following form:

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

- This insurance provides benefits primarily for covered home care services.
- In some situations, Medicare will cover some health related services in your home and hospice care which may also be covered by this insurance.
- This insurance does not pay your Medicare deductibles for coinsurance and is not a substitute for Medicare Supplement Insurance.

Neither Medicare nor Medicare Supplement Insurance provides benefits for most services in your home.

Before You Buy This Insurance:

- Check the coverage in **all** health insurance policies you already have.
- For more information about long-term care insurance, review "The Shopper's Guide to Long-Term Care Insurance," which is available from the insurance company.
- For more information about Medicare and Medicare Supplement Insurance, review "The Guide to Health Insurance for People with Medicare," which is available from the insurance company.
- For help in understanding your health insurance, contact the Commissioner of Insurance or the Nevada Medicare Information, Counseling and Assistance Program.

687B.715 Notice of duplication for policy which provides benefits for long-term care.

1. An insurer that delivers or issues for delivery in this state a policy of insurance which provides benefits for long-term care, including nursing home care and noninstitutional care and which provides benefits that are provided under Medicare shall provide notice to the insured that the policy contains certain benefits which are also provided under Medicare.

2. The notice must be:

(a) Printed on or attached to the first page of the application for the policy; and

(b) If not less than 12-point type and contain the following language in substantially the following form:

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

- This is long-term care insurance that provides benefits for covered nursing home and home care services.
- In some situations Medicare pays for short periods of skilled nursing home care, limited home health services and hospice care.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement Insurance.

Neither Medicare nor Medicare Supplement Insurance provides benefits for most long-term care expenses.

Before You Buy This Insurance:

- Check the coverage in **all** health insurance policies you already have.
- For more information about long-term care insurance, review "The Shopper's Guide to Long-Term Care Insurance," which is available from the insurance company.
- For more information about Medicare and Medicare Supplement Insurance, review "The Guide to Health Insurance for People with Medicare," which is available from the insurance company.
- For help in understanding your health insurance, contact the Commissioner of Insurance or the Nevada Medicare Information, Counseling and Assistance Program.