NOTICE OF INTENT TO ACT UPON REGULATION
AND
HEARING AGENDA

Notice of Hearing for the Adoption, Amendment or Repeal of Regulations of
The Department of Business and Industry, Division of Insurance

The State of Nevada, Department of Business and Industry, Division of Insurance ("Division"), (775) 687-0700, will hold a public hearing at **9:30 a.m.**, on **April 29, 2019,** in the 1st Floor Hearing Room, 1818 East College Parkway, Suite 103, Carson City, Nevada 89706. Interested persons may also participate through a simultaneous videoconference conducted in the 4th Floor Tahoe Room at the Nevada State Business Center / Division of Insurance, 3300 West Sahara Avenue, Suite 275, Las Vegas, Nevada 89102. The purpose of the hearing is to receive comments from all interested persons regarding the adoption, amendment or repeal of regulations pertaining to chapter 687B of the Nevada Administrative Code ("NAC").

The following information is provided pursuant to the requirements of Nevada Revised Statutes ("NRS") 233B.0603:

LCB File No. R041-17. Medicare Supplement.
A regulation relating to insurance; providing for 2020 standardized benefit plans to supplement Medicare; revising requirements applicable to 2010 standardized benefit plans to supplement Medicare; revising the forms for outlines of coverage provided to applicants for standardized benefit plans to supplement Medicare; and providing other matters properly relating thereto.

(1) Why is the regulation necessary and what is its purpose?

This regulation revises the current Medicare Supplement Regulation (NAC 687B) to become compliant with the federal Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA").

(2) What are the terms or substance of the proposed regulation?

MACRA prohibits the sale of Medigap policies that cover Part B deductibles to "newly eligible" Medicare beneficiaries defined as those individuals who: (a) have attained age 65 on or after January 1, 2020; or (b) first become eligible for Medicare due to age, disability or end-stage renal disease, on or after January 1, 2020.

The proposed regulation pertains to Medicare Supplement policies being sold in the State of Nevada, and allows the state to be compliant with MACRA. MACRA contains the rules on coverage, benefits and limitations for those types of policies, and the guidance for issuing this regulation was provided by the NAIC Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651-53).

(3) What is the anticipated impact of the regulation on the problem(s)?

For "newly eligible" persons, references in the current Medicare Supplement regulation to Medigap plans C and F are deemed as references to plans D and G.

(4) Do other regulations address the same problem(s)?

No.

(5) Are alternate forms of regulation sufficient to address the problem(s)?

No.

(6) What value does the regulation have to the public?

This regulation amends current law to become compliant with federal law for the regulation of Medicare Supplement policies.

(7) What is the anticipated economic benefit of the regulation?

a. Public
   1. Immediate: *None.*
   2. Long Term: *None.*

b. Insurance Business
   1. Immediate: *None.*
   2. Long Term: *None.*

c. Small Businesses
   1. Immediate: *None.*
   2. Long Term: *None.*

d. Small Communities
   1. Immediate: *None.*
   2. Long Term: *None.*

e. Government Entities
   1. Immediate: *None.*
   2. Long Term: *None.*

(8) What is the anticipated adverse impact, if any?

a. Public
   1. Immediate: *"Newly eligible" people who sign up for Medicare Supplement plans will not have the option to choose a plan that covers Part B deductibles and will have to pay this fee instead.*

2. Long Term: *"Newly eligible" people who sign up for Medicare Supplement plans will not have the option to choose a plan that covers Part B deductibles and will have to pay this fee instead.*

b. Insurance Business
   1. Immediate: *None.*
   2. Long Term: *None.*

c. Small Businesses
   1. Immediate: *None.*
   2. Long Term: *None.*

d. Small Communities
   1. Immediate: *None.*
   2. Long Term: *None.*

e. Government Entities
   1. Immediate: *None.*
   2. Long Term: *None.*

(9) What is the anticipated cost of the regulation, both direct and indirect?

a. Enactment: *No cost, either directly or indirectly.*
b. Enforcement: *No cost, either directly or indirectly.*
c. Compliance: *No cost, either directly or indirectly.*

(10) Does the regulation establish a new fee or increase an existing fee?

No, there are no fees associated with this regulation.

(11) Provide a statement which identifies the methods used by the agency in determining the impact of the proposed regulation on a small business, prepared pursuant to subsection 3 of NRS 233B.0608.

This regulation was reviewed and discussed by the Life and Health Section of the Nevada Division of Insurance. The experience and expertise of the section members were used to analyze the proposed language of the regulation, and they determined that no impact on small business would be made by these changes.

(12) Provide a description of any regulations of other state or local governmental agencies which the proposed regulation overlaps or duplicates, and a statement explaining why the duplication or overlapping is necessary. If the regulation overlaps or duplicates a federal regulation, state the name of the regulating federal agency.

The Division reviewed existing regulations and determined that there is no overlap or duplication with other state or local governmental agencies. The proposed regulation does not

duplicate federal regulation, however, it is required under the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA").

(13) If the regulation is required pursuant to federal law, provide a citation and description of the federal law.

The Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA") was signed into law on April 16, 2015. MACRA prohibits the sale of Medigap policies that cover Part B deductibles to "newly eligible" Medicare beneficiaries defined as those individuals who: (a) have attained age 65 on or after January 1, 2020; or (b) first become eligible for Medicare due to age, disability or end-stage renal disease, on or after January 1, 2020.

The proposed regulation pertains to Medicare Supplement policies being sold in the State of Nevada, and allows the state to be compliant with MACRA. MACRA contains the rules on coverage, benefits and limitations for those types of policies, and the guidance for issuing this regulation was provided by the NAIC Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651-53).

(14) If the regulation includes provisions which are more stringent than a federal regulation that regulates the same activity, provide a summary of such provisions.

Division personnel deemed subject matter experts analyzed the proposed regulation and existing federal regulations and determined that the regulation does not include more stringent provisions and meets the standards identified in federal regulation.

Persons wishing to comment upon the proposed actions 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, 1818 East College Parkway, Suite 103, Carson City, Nevada 89706. **Written submissions must be received by the Division on or before April 22, 2019.** 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 regulation to be adopted, amended or repealed will be on file at the State Library, 100 North Stewart Street, Carson City, Nevada, for inspection by members of the public during business hours. Additional copies of the notice and the regulation will be available at the offices of the Division, 1818 East College Parkway, Suite 103, Carson City, Nevada 89706, and 3300 West Sahara Avenue, Suite 275, Las Vegas, Nevada 89102, 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://leg.state.nv.us/register/**. Copies of this notice and the proposed regulation will be mailed to members of the public upon request. A reasonable fee may be charged for copies if it is deemed necessary. This does not apply to a public body subject to the Open Meeting Law.

Upon adoption of any regulation, the agency, if requested to do so by an interested person, either before adoption or within 30 days thereafter, shall 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.

Notice of the hearing was provided via electronic means to all persons on the agency's e-mail list for administrative regulations, and this Notice of Intent to Act Upon Regulation was posted to the agency's Internet Web site at **http://doi.nv.gov/** and was provided to or posted at the following locations:

Nevada Division of Insurance
1818 East College Parkway, Suite 103
Carson City, Nevada 89706

Nevada Division of Insurance
3300 West Sahara Avenue, Suite 275
Las Vegas, Nevada 89102

Legislative Building
401 South Carson Street
Carson City, Nevada 89701

Nevada State Business Center
3300 West Sahara Avenue
Las Vegas, Nevada 89102

Blasdel Building
209 East Musser Street
Carson City, Nevada 89701

Grant Sawyer Building
555 East Washington Avenue
Las Vegas, Nevada 89101

Capitol Building Main Floor
101 North Carson Street
Carson City, Nevada 89701

Nevada Department of Employment,
Training and Rehabilitation
2800 E. Saint Louis Avenue
Las Vegas, NV 89104

Nevada State Library & Archives
100 North Stewart Street
Carson City, Nevada 89701

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

Churchill County Library
553 South Main Street
Fallon, Nevada 89406

Douglas County Public Library
1625 Library Lane
P.O. Box 337
Minden, Nevada 89423-0337

Elko County Library
720 Court Street
Elko, Nevada 89801

Goldfield Public Library/Esmeralda County
Corner of Crook Ave. and Fourth St.
P.O. Box 430
Goldfield, Nevada 89013

Eureka Branch Library
80 S. Monroe Street
P.O. Box 293
Eureka, Nevada 89316-0293

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

Lander County Library
625 S. Broad Street
P.O. Box 141
Battle Mountain, Nevada 89820

Las Vegas-Clark County Library District
7060 W. Windmill Lane
Las Vegas, NV 89113

Lincoln County Library
63 Main Street
P.O. Box 330
Pioche, Nevada 89043-0330

Lyon County Library
20 Nevin Way
Yerington, Nevada 89447

Mineral County Public Library
110 1st Street
P.O. Box 1390
Hawthorne, Nevada 89415

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

Storey County Clerk
26 S. B Street
P.O. Drawer D
Virginia City, Nevada 89440

Tonopah Public Library
167 S. Central Street
P.O. Box 449
Tonopah, Nevada 89049

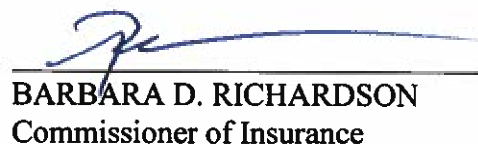
Downtown Reno Library/Washoe County
301 S. Center Street
P.O. Box 2151
Reno, Nevada 89505-2151

White Pine County Library
950 Campton Street
Ely, Nevada 89301

Members of the public who would like additional information about the proposed regulation may contact Susan Bell, Legal Secretary, at (775) 687-0704, or via e-mail to suebell@doi.nv.gov.

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, no later than five (5) working days before the hearing: 1818 E. College Parkway, Suite 103, Carson City, Nevada 89706, or suebell@doi.nv.gov.

DATED this 22nd day of March, 2019.



BARBARA D. RICHARDSON
Commissioner of Insurance

HEARING AGENDA

The State of Nevada Department of Business and Industry
Division of Insurance

April 29, 2019 • 9:30 a.m.

Location of Hearing:
Nevada Division of Insurance
1818 E. College Pkwy., 1st Floor Hearing Room
Carson City, NV 89706
(Division Offices located in Suite 103)

Available via Videoconference at:
Nevada Division of Insurance
3300 W. Sahara Ave., 4th Floor Tahoe Room
Las Vegas, NV 89102
(Division Offices located in Suite 275)

1. Open Hearing: R041-17.

2. Presentation, Discussion and Adoption of Proposed Regulation. (For Possible Action)

   LCB File No. R041-17. Medicare Supplement.
   A regulation relating to insurance; providing for 2020 standardized benefit plans to supplement Medicare; revising requirements applicable to 2010 standardized benefit plans to supplement Medicare; revising the forms for outlines of coverage provided to applicants for standardized benefit plans to supplement Medicare; and providing other matters properly relating thereto.

3. Public Comment.

4. Close Hearing: R041-17.

5. Adjourn.

Supporting public material for this hearing may be requested from Susan Bell, Legal Secretary, Nevada Division of Insurance, 1818 E. College Parkway, Carson City, Nevada 89706, (775) 687-0704, or suebell@doi.nv.gov.

Note: Any agenda item may be taken out of order; items may be combined for consideration by the public body; items may be pulled or removed from the agenda at any time; and, discussion relating to an item may be delayed or continued at any time. The Hearing Officer, within his/her discretion, may allow for public comment on individual agenda items. Public comment may be limited to three minutes per speaker.

Members of the public are encouraged to submit written comments for the record.

We are pleased to make reasonable accommodations for attendees with disabilities. Please notify the Commissioner's secretary, in writing, no later than five (5) working days before the hearing: 1818 E. College Parkway, Suite 103, Carson City, Nevada 89706, or suebell@doi.nv.gov.

NOTICES FOR THIS HEARING HAVE BEEN POSTED IN ACCORDANCE WITH NRS 241 AT THE FOLLOWING LOCATIONS:
Nevada Division of Insurance, 1818 E. College Parkway, Suite 103, Carson City, Nevada 89706
Nevada Division of Insurance, 3300 W. Sahara Avenue, Suite 275, Las Vegas, Nevada 89102
Nevada State Business Center, 3300 W. Sahara Avenue, Las Vegas, Nevada 89102
Nevada State Legislative Building, 401 S. Carson Street, Carson City, Nevada 89701
Grant Sawyer State Office Building, 555 E. Washington Avenue, Las Vegas, Nevada 89101
Blasdel State Office Building, 209 E. Musser Street, Carson City, Nevada 89701
Nevada State Capitol, 101 N. Carson Street, Carson City, Nevada 89701
Nevada Dept. of Employment, Training and Rehabilitation, 2800 E. Saint Louis Avenue, Las Vegas, Nevada 89104
The State of Nevada Website (www.nv.gov)
The Nevada State Legislature Website (www.leg.state.nv.us)
The Nevada Division of Insurance Website (www.doi.nv.gov)

STATE OF NEVADA
DEPARTMENT OF BUSINESS & INDUSTRY
DIVISION OF INSURANCE

Determination of Necessity - Small Business Impact Statement
NRS 233B.0608(1)

Medicare Supplement Regulation

EFFECTIVE DATE OF REGULATION:
Upon filing with the Nevada Secretary of State

1. BACKGROUND.

This regulation is needed to bring the current Medicare Supplement regulation (NAC 687B) into compliance with the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA") that was signed into law on April 16, 2015.

2. DESCRIPTION OF SOLICITATION SHOWING A CONCERTED EFFORT. NRS 233B.0608(1).

A solicitation of this regulation was not made with small businesses in Nevada, as none of the proposed changes in this regulation impact small business. This regulation affects NAC 687B, which applies to Medicare Supplement Insurance. This affects individuals and not businesses.

3. DOES THE PROPOSED REGULATION IMPOSE A DIRECT AND SIGNIFICANT ECONOMIC BURDEN UPON A SMALL BUSINESS OR DIRECTLY RESTRICT THE FORMATION, OPERATION OR EXPANSION OF A SMALL BUSINESS? NRS 233B.0608(1).

☒ NO ☐ YES

4. HOW WAS THAT CONCLUSION REACHED? NRS 233B.0608(3).

This regulation amends existing regulation, NAC 687B, to bring it into compliance with MACRA. Individuals have Medicare Supplement policies and this is not something that places any economic burden upon a small business and does not restrict the formation, operation or expansion of a small business in any way.

I, BARBARA D. RICHARDSON, Commissioner of Insurance for the State of Nevada, hereby certify to the best of my knowledge or belief a concerted effort was made to determine the impact of the proposed regulation on small businesses and that this statement was prepared properly and the information contained herein is accurate. (NRS 233B.0608(3))

7/21/17
(DATE)

BARBARA D. RICHARDSON
Commissioner of Insurance

Small Business Impact Statement
NRS 233B.0608(2)-(4) and 233B.0609

Medicare Supplement Regulation

1. SUMMARY OF COMMENTS RECEIVED FROM SMALL BUSINESSES. NRS 233B.0609(1)(a).

No comments were received, as this regulation only impacts individuals purchasing Medicare Supplement policies.

Other interested parties may receive a copy of this summary by contacting Susan Bell, Legal Secretary, Nevada Division of Insurance, at (775) 687-0704 or suebell@doi.nv.gov.

2. HOW WAS THE ANALYSIS CONDUCTED? NRS 233B.0609(1)(b).

This regulation was reviewed and discussed by the Life and Health Section of the Nevada Division of Insurance. The experience and expertise of the section members were used to analyze the proposed language of the regulation, and they determined that no impact on small business would be made by these changes.

3. ESTIMATED ECONOMIC EFFECT ON SMALL BUSINESSES THE REGULATION IS TO REGULATE. NRS 233B.0609(1)(c).

There are no economic effects on small businesses.

4. METHODS CONSIDERED TO REDUCE IMPACT ON SMALL BUSINESSES. NRS 233B.0609(1)(d).

No methods were used to reduce the impact on small businesses as this regulation has no effect on small businesses.

5. ESTIMATED COST OF ENFORCEMENT. NRS 233B.0609(1)(e).

There is no additional cost to the Division of Insurance to enforce this regulation as this is something the Division of Insurance does already.

6. FEE CHANGES. NRS 233B.0609(1)(f).

This regulation does not create new fees and there are no existing fees associated with this regulation.

7. DUPLICATIVE PROVISIONS. NRS 233B.0609(1)(g).

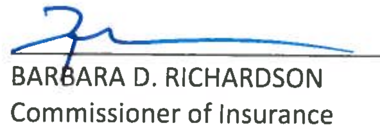
This regulation duplicates federal law. If Nevada does not implement MACRA, then the federal government would assume authority to regulate Medicare Supplement insurance in Nevada. This regulation is not more stringent than any existing federal, state or local standards.

8. <u>REASONS FOR CONCLUSIONS. NRS 233B.0609(1)(h).</u>

Medicare Supplement policies are to supplement an individual's Medicare insurance. This is not something that affects businesses.

I, BARBARA D. RICHARDSON, Commissioner of Insurance for the State of Nevada, hereby certify to the best of my knowledge or belief a concerted effort was made to determine the impact of the proposed regulation on small businesses and that this statement was prepared properly and the information contained herein is accurate. (NRS 233B.0609(2))

7/21/17
(DATE)


BARBARA D. RICHARDSON
Commissioner of Insurance

REVISED PROPOSED REGULATION OF

THE COMMISSIONER OF INSURANCE

LCB File No. R041-17

March 12, 2019

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

AUTHORITY: §§1-16, NRS 679B.130 and 687B.430.

A REGULATION relating to insurance; providing for 2020 standardized benefit plans to supplement Medicare; revising requirements applicable to 2010 standardized benefit plans to supplement Medicare; revising the forms for outlines of coverage provided to applicants for standardized benefit plans to supplement Medicare; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law authorizes the Commissioner of Insurance to adopt reasonable regulations for the administration of the Nevada Insurance Code and reasonable regulations as required to ensure compliance with federal law relating to insurance. (NRS 679B.130) Existing law also authorizes the Commissioner to adopt regulations relating to the form, content and sale of policies of insurance which provide for the payment of expenses which are not covered by Medicare. (NRS 687B.430)

A policy of insurance which provides for the payment of expenses which are not covered by Medicare is commonly referred to as a Medicare supplement policy or a Medigap policy, among other common names, and is referred to in existing regulations as a policy to supplement Medicare or a standardized benefit plan to supplement Medicare. (NAC 687B.204, 687B.2045) Existing regulations govern the form, content and sale of such policies to supplement Medicare. (NAC 687B.200-687B.330) Specifically, existing regulations govern 1990 standardized benefit plans to supplement Medicare, which are policies to supplement Medicare that were issued on or after January 1, 1992, and with an effective date for coverage before June 1, 2010. (NAC 687B.2002) Existing regulations also govern 2010 standardized benefit plans to supplement Medicare, which are policies to supplement Medicare that were issued with an effective date for coverage on or after June 1, 2010. (NAC 687B.2003)

Congress revised federal law relating to policies to supplement Medicare when it enacted the Medicare Access and CHIP Reauthorization Act of 2015, commonly known as MACRA. (Public Law 114-10) Among other changes, MACRA revised the federal requirements applicable to policies to supplement Medicare issued to persons newly eligible for Medicare on or after January 1, 2020. This regulation revises existing Nevada regulations governing policies to supplement Medicare to make the Nevada regulations consistent with federal requirements as revised by MACRA. Specifically, this regulation provides for 2020 standardized benefit plans to

supplement Medicare for persons newly eligible for Medicare on or after January 1, 2020, and revises requirements relating to 2010 standardized benefit plans to supplement Medicare as needed to account for the 2020 standardized benefit plans to supplement Medicare. The primary substantive difference between the 2010 standardized benefit plans to supplement Medicare, which may continue to be issued after January 1, 2020, only to persons who were eligible for Medicare before January 1, 2020, and the 2020 standardized benefit plans to supplement Medicare, which are the only policies to supplement Medicare which may be issued to persons newly eligible for Medicare on or after January 1, 2020, is that the 2020 standardized benefit plans to supplement Medicare are prohibited from providing any coverage for any portion of Medicare Part B deductibles.

Sections 2-4 of this regulation set forth definitions of "2020 standardized benefit plan to supplement Medicare," "newly eligible before January 1, 2020" and "newly eligible on or after January 1, 2020," as needed to set forth separate requirements applicable to the 2020 standardized benefit plans to supplement Medicare issued to persons newly eligible on or after January 1, 2020.

Section 5 of this regulation prohibits the issuance or provision of specified policies, plans and benefits to persons newly eligible on or after January 1, 2020, while expressly retaining requirements applicable to 2010 standardized benefit plans to supplement Medicare. **Section 5** also provides for the issuance of the new High Deductible Benefit Plan G to persons otherwise eligible to be issued 2010 standardized benefit plans to supplement Medicare.

Section 6 of this regulation sets forth the requirements applicable to 2020 standardized benefit plans to supplement Medicare, including the creation of the new High Deductible Benefit Plan G. **Sections 7-13, 15 and 16** of this regulation make conforming changes consistent with the requirements set forth in **section 6**.

Section 14 of this regulation revises the forms for the outlines of coverage which must be provided to applicants for standardized benefit plans to supplement Medicare.

Section 1. Chapter 687B of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 6, inclusive, of this regulation.

Sec. 2. ***"2020 standardized benefit plan to supplement Medicare" means a policy to supplement Medicare issued to an individual who is newly eligible on or after January 1, 2020.***

Sec. 3. ***"Newly eligible before January 1, 2020" means an individual who:***

1. Becomes 65 years of age before January 1, 2020; or

2. First becomes eligible for Medicare benefits because of age, disability or end-stage renal disease before January 1, 2020.

Sec. 4. ***"Newly eligible on or after January 1, 2020" means an individual who:***

1. Becomes 65 years of age on or after January 1, 2020; or

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

Sec. 5. *1. An issuer shall not advertise, solicit, deliver or issue for delivery in this State to an individual who is newly eligible on or after January 1, 2020, a:*

(a) Standardized Benefit Plan C;

(b) Standardized Benefit Plan F; or

(c) High Deductible Benefit Plan F.

2. A policy to supplement Medicare, or a certificate, which is advertised, solicited, delivered or issued for delivery in this State to an individual who is newly eligible on or after January 1, 2020, must not provide coverage for any portion of the Medicare Part B deductible.

3. On or after January 1, 2020:

(a) An issuer shall not advertise, solicit, deliver or issue for delivery in this State a policy to supplement Medicare, or a certificate, unless the policy or certificate:

(1) Complies with the standards applicable to a 2020 standardized benefit plan to supplement Medicare, including, without limitation, the standards set forth in NAC 687B.250 and section 6 of this regulation; or

(2) Is advertised, solicited, delivered or issued for delivery to an individual who is newly eligible before January 1, 2020.

(b) The benefit standards applicable to a policy to supplement Medicare, or a certificate, remain subject to all requirements applicable to a 2010 standardized benefit plan to supplement Medicare, including, without limitation, NAC 687B.2003, 687B.2273, 687B.250, 687B.322 and 687B.323, if the policy or certificate:

(1) Was issued with an effective date for coverage on or after June 1, 2010; and

(2) Is issued to an individual who is newly eligible before January 1, 2020.

(c) In addition to the 2010 standardized benefit plans to supplement Medicare described in subsection 7 of NAC 687B.323, an issuer may offer for sale the standardized benefit plan described in paragraph (c) of subsection 3 of section 6 of this regulation, referred to as a High Deductible Benefit Plan G, to an individual who is newly eligible before January 1, 2020.

Sec. 6. *1. The standards set forth in this section are applicable to every 2020 standardized benefit plan to supplement Medicare.*

2. Except as otherwise provided in subsection 3, a 2020 standardized benefit plan to supplement Medicare must comply with the requirements applicable to a 2010 standardized benefit plan to supplement Medicare, as set forth in NAC 687B.200 to 687B.330, inclusive, and sections 2 to 6 inclusive, of this regulation, including, without limitation, NAC 687B.2057, 687B.206, 687B.2062, 687B.250, 687B.322 and 687B.323.

3. For the purposes of a 2020 standardized benefit plan to supplement Medicare:

(a) In NAC 687B.2057, 687B.206 and 687B.2062:

(1) The references to Standardized Benefit Plan C, Plan C or C policy shall be deemed to be references to Standardized Benefit Plan D, Plan D or D policy, as applicable;

(2) The references to Standardized Benefit Plan F, Plan F or F policy shall be deemed to be references to Standardized Benefit Plan G, Plan G or G policy, as applicable; and

(3) The references to Standardized Benefit Plan F with a high deductible, Plan F with a high deductible or F with a high deductible policy shall be deemed to be references to Standardized Benefit Plan G with a high deductible, Plan G with a high deductible or G with a high deductible policy, as applicable.

(b) In subsection 3 of NAC 687B.323:

(1) The reference to a Standardized Benefit Plan C as described in paragraph (c) of subsection 7 of NAC 687B.323 shall be deemed to be a reference to a Standardized Benefit Plan D as described in paragraph (d) of subsection 7 of NAC 687B.323; and

(2) The reference to a Standardized Benefit Plan F as described in paragraph (e) of subsection 7 of NAC 687B.323 shall be deemed to be a reference to a Standardized Benefit Plan G as described in paragraph (g) of subsection 7 of NAC 687B.323.

(c) In paragraph (f) of subsection 7 of NAC 687B.323, the reference to a Standardized Benefit Plan F shall be deemed to be a reference to a Standardized Benefit Plan G and the reference to a High Deductible Benefit Plan F shall be deemed to be a reference to a High Deductible Benefit Plan G. Such a High Deductible Benefit Plan G must provide:

(1) The benefits specified in paragraph (f) of subsection 7 of NAC 687B.323 except that it must not provide coverage for any portion of the Medicare Part B deductible; and

(2) That any amount paid by the beneficiary for the Medicare Part B deductible is an out-of-pocket expense for the purpose of the annual deductible.

Sec. 7. NAC 687B.200 is hereby amended to read as follows:

687B.200 As used in NAC 687B.200 to 687B.330, inclusive, ***and sections 2 to 6, inclusive, of this regulation,*** unless the context otherwise requires, the words and terms defined in NAC 687B.2002 to 687B.2045, inclusive, ***and sections 2, 3 and 4 of this regulation*** have the meanings ascribed to them in those sections.

Sec. 8. NAC 687B.2003 is hereby amended to read as follows:

687B.2003 "2010 standardized benefit plan to supplement Medicare" or "2010 standardized benefit plan" means a policy to supplement Medicare issued with an effective date for coverage

on or after June 1, 2010 [.] ***, and which is not issued to an individual who is newly eligible on or after January 1, 2020.***

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

687B.2045 "Standardized benefit plan" means ***, as applicable,*** a benefit plan to supplement Medicare that is designated as Standardized Benefit Plan A through N, inclusive, or High Deductible Benefit Plan F ***, G*** or J, as set forth in NAC 687B.300 to 687B.323, inclusive [.] ***, and section 6 of this regulation.***

Sec. 10. NAC 687B.2057 is hereby amended to read as follows:

687B.2057 [The] ***Except as otherwise provided in section 6 of this regulation, the*** policy to supplement Medicare to which eligible persons are entitled:

1. Under paragraphs (a), (b), (c) and (d) of subsection 3 of NAC 687B.2053 is a policy to supplement Medicare that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L offered by any issuer;

2. Subject to paragraph (e) of subsection 3 of NAC 687B.2053 is the same policy to supplement Medicare in which the person was most recently and previously enrolled, if available from the same issuer or, if not so available, a policy described in subsection 1;

3. After December 31, 2005, if the person was most recently enrolled in a policy to supplement Medicare with an outpatient prescription drug benefit, a policy to supplement Medicare described in this subsection is:

(a) The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or

(b) At the election of the policyholder, an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer;

4. Under paragraph (f) of subsection 3 of NAC 687B.2053 shall include any policy to supplement Medicare offered by any issuer; or

5. Under paragraph (g) of subsection 3 of NAC 687B.2053 is a policy to supplement Medicare that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the policy to supplement Medicare with outpatient prescription drug coverage.

Sec. 11. NAC 687B.206 is hereby amended to read as follows:

687B.206 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 the person provides evidence that he or she 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 Advantage plan offered by a Medicare Advantage organization pursuant to Medicare Part C, if the person was allowed to disenroll from the Medicare Advantage plan under any of the following circumstances:

(1) The certification of the organization or the plan has been terminated, or the organization or plan has notified the person of an impending termination of its certification.

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

(3) The person was no longer eligible to elect a Medicare Advantage plan because:

(I) His or her residence changed;

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

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

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

(I) The Medicare Advantage organization offering the Medicare Advantage plan substantially violated a material provision of the contract of the Medicare Advantage 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 Advantage plan or failing to provide such care in accordance with applicable quality standards; or

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

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

(d) The PACE program if the person is 65 years of age or older and there are circumstances similar to those described in paragraph (c) that would permit discontinuance of the person's enrollment with the provider if he or she were enrolled in a Medicare Advantage plan.

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

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

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

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

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

(f) 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. In lieu of using the date of termination of enrollment for purposes of this section, a person described in paragraph (c) or (d) of subsection 1 may substitute the date on which he or she was notified by the Medicare Advantage organization of the impending termination or discontinuance of the Medicare Advantage plan offered by the Medicare Advantage organization in the area in which the person resides, but only if the person disenrolls from the plan as a result of that notification. If a person makes the substitution provided in this subsection, the issuer shall accept the application of the person submitted before the date of termination or enrollment, but the coverage under this subsection must become effective only upon termination of coverage under the Medicare Advantage plan involved.

3. ~~[A]~~ ***Except as otherwise provided in section 6 of this regulation, 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 (including F with a high deductible), K or L.

4. ~~[After]~~ ***Except as otherwise provided in section 6 of this regulation, after*** December 31, 2005, a person currently enrolled in a policy to supplement Medicare with an outpatient prescription drug benefit is eligible to:

(a) Retain their current plan with outpatient prescription drug coverage;

(b) Enroll in a plan from the same issuer that is modified to exclude outpatient prescription drug coverage with the option to select Medicare Part D; or

(c) Enroll in an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer with an option to select Medicare Part D.

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

Sec. 12. NAC 687B.2062 is hereby amended to read as follows:

687B.2062 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 the person provides evidence that he or she:

(a) Disenrolled from such a policy or certificate;

(b) Subsequently enrolled for the first time in:

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

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

(3) Any PACE program; and

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

2. ~~[A]~~ ***Except as otherwise provided in section 6 of this regulation, 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 or her 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, the person 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 (including F with a high deductible), K or L.

Sec. 13. NAC 687B.2273 is hereby amended to read as follows:

687B.2273 1. ~~[On]~~ ***Except as otherwise provided in section 6 of this regulation, on*** or after June 1, 2010, no policy or certificate may be advertised, solicited, delivered or issued for delivery in this State as a policy to supplement Medicare or a certificate unless it complies with the standards provided for in NAC 687B.322 and 687B.323.

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

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

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

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

2. If an outline of coverage is provided at the time of application and the policy to supplement Medicare or the certificate is issued on a basis that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must

accompany the policy or certificate when it is delivered. The substitute outline must contain the following statement, in not less than 12-point type, immediately above the name of the company:

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

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

(a) A cover page;

(b) Information regarding premiums;

(c) Disclosure pages; and

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

4. All plans must be shown on the cover page and the plans offered by the issuer must be prominently identified.

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

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

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

Benefit Chart of Medicare Supplement Plans Sold with an Effective Date for Coverage
On or After June 1, 2010 ***, and Before January 1, 2020***

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

Basic Benefits:
Hospitalization - Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses - Part B coinsurance (generally 20 percent of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
Blood - First three pints of blood each year.
Hospice - Part A coinsurance.

A	B	C	D	F F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to *** copayment for office visit, and up to *** copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit**; paid at 100% after limit reached	Out-of-pocket limit**; paid at 100% after limit reached		

* Plan F also has an option called a High Deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses exceed the deductible. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These

expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

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

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

Benefit Chart of Medicare Supplement Plans Sold with an Effective Date for Coverage On or After January 1, 2020

This chart shows the benefits included in each of the Standard Medicare Supplement plans. Some plans may not be available. Only applicants first eligible for Medicare before 2020 may purchase Plans C, F and High Deductible F.

Note: A ✔ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare First Eligible Before 2020 Only	
	A	B	D	G[1]	K	L	M	N	C	F [1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Medicare Part B coinsurance or Copayment	✔	✔	✔	✔	50%	75%	✔	✔ copays apply[3]	✔	✔
Blood (first three pints)	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Part A hospice care coinsurance or copayment	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Skilled nursing facility coinsurance			✔	✔	50%	75%	✔	✔	✔	✔
Medicare Part A Deductible		✔	✔	✔	50%	75%	50%	✔	✔	✔
Medicare Part B Deductible									✔	✔
Medicare Part B excess charges				✔						✔
Foreign travel emergency (up to plan limits)			✔	✔			✔	✔	✔	✔
Out-of-pocket limit [2]					** 2	** 2				

[1] Plans F and G also have a high deductible option which require first paying a plan deductible before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High Deductible Plan G does not cover the Medicare Part B Deductible. However, high deductible plans F and G count your payment of the Medicare Part B Deductible toward meeting the plan deductible.

[2] Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3] Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in an inpatient admission.

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

PREMIUM INFORMATION (Boldface type)

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

DISCLOSURES (Boldface type)

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY
(Boldface type)

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

RIGHT TO RETURN POLICY (Boldface type)

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

POLICY REPLACEMENT (Boldface type)

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

NOTICE (Boldface type)

This policy may not cover all of your medical costs.

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

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT
(Boldface type)

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

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

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

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

PLAN A

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

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

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

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

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

PLAN A

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

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

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

PLAN A

PARTS A & B

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

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

PLAN B

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

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

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

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

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

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

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

PLAN B

PARTS A & B

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

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

PLAN C

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

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

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

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

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

PLAN C

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

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

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

PLAN C

PARTS A & B

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

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

PLAN C

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

PLAN D

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

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

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

PLAN D

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

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

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

PLAN D

PARTS A & B

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

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

PLAN D

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

[PLAN F

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

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

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

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

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

PLAN F

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

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

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

PLAN F

PARTS A & B

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

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

PLAN F

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

HIGH DEDUCTIBLE BENEFIT PLAN F

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

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

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

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

**** The High Deductible Benefit Plan F pays the same benefits as the Standardized Benefit Plan F after one has paid a calendar year deductible. The annual deductible for the High Deductible Benefit Plan F is subject to change. For the current deductible, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. Benefits from the High Deductible Benefit Plan F will not begin until out-of-pocket expenses are equal to the calendar year deductible. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes, without limitation, the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

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

HIGH DEDUCTIBLE BENEFIT PLAN F

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

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

** The High Deductible Benefit Plan F pays the same benefits as the Standardized Benefit Plan F after one has paid a calendar year deductible. The annual deductible for the High Deductible Benefit Plan F is subject to change. For the current deductible, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by

an issuer to an applicant pursuant to NAC 687B.240. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. Benefits from the High Deductible Benefit Plan F will not begin until out-of-pocket expenses are equal to the calendar year deductible. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes, without limitation, the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

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

HIGH DEDUCTIBLE BENEFIT PLAN F

MEDICARE (PARTS A & B)

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

** The High Deductible Benefit Plan F pays the same benefits as the Standardized Benefit Plan F after one has paid a calendar year deductible. The annual deductible for the High Deductible Benefit Plan F is subject to change. For the current deductible, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. Benefits from the High Deductible Benefit Plan F will not begin until out-of-pocket expenses are equal to the calendar year deductible. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes, without limitation, the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

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

HIGH DEDUCTIBLE BENEFIT PLAN F

OTHER BENEFITS - NOT COVERED BY MEDICARE

* The High Deductible Benefit Plan F pays the same benefits as the Standardized Benefit Plan F after one has paid a calendar year deductible. The annual deductible for the High Deductible Benefit Plan F is subject to change. For the current deductible, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. Benefits from the High Deductible Benefit Plan F will not begin until out-of-pocket expenses are equal to the calendar year deductible. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes, without limitation, the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

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

PLAN G

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

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

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

PLAN G

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

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

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

PLAN G

PARTS A & B

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

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

PLAN G

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

PLAN F or HIGH DEDUCTIBLE PLAN F

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

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

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

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

******* The High Deductible Benefit Plan F pays the same benefits as the Standardized Benefit Plan F after you have paid a calendar year deductible. The annual deductible for the High Deductible Benefit Plan F is subject to change. For the current deductible, please consult the most current version of the Guide to Health Insurance for People with Medicare, which must be provided by an issuer to an applicant pursuant to NAC 687B.240. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. Benefits from the High Deductible Benefit Plan F will not begin until out-of-pocket expenses are equal to the calendar year deductible. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes, without limitation, the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.***

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

SERVICES	***MEDICARE PAYS***	***AFTER YOU PAY THE DEDUCTIBLE, PLAN PAYS *******	***IN ADDITION TO THE DEDUCTIBLE, YOU PAY *******
SKILLED NURSING FACILITY CARE* ***You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:***			
First 20 days	***All approved amounts***	***$0***	***$0***
21st thru 100th day	***All but ** a day***	***Up to ** a day***	***$0***
101st day and after	***$0***	***$0***	***All costs***
BLOOD			
First 3 pints	***$0***	***3 pints***	***$0***
Additional amounts	***100%***	***$0***	***$0***
HOSPICE CARE ***You must meet Medicare's requirements, including a doctor's certification of terminal illness***	***All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care***	***Medicare copayment/ coinsurance***	***$0***

PLAN F or HIGH DEDUCTIBLE PLAN F

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

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

******* The High Deductible Benefit Plan F pays the same benefits as the Standardized Benefit Plan F after you have paid a calendar year deductible. The annual deductible for the High Deductible Benefit Plan F is subject to change. For the current deductible, please consult the most current version of the Guide to Health Insurance for People with Medicare, which must be provided by an issuer to an applicant pursuant to NAC 687B.240. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. Benefits from the High Deductible Benefit Plan F will not begin until out-of-pocket expenses are equal to the calendar year deductible. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes, without limitation, the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.***

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

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

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

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

***** The High Deductible Benefit Plan F pays the same benefits as the Standardized Benefit Plan F after you have paid a calendar year deductible. The annual deductible for the High Deductible Benefit Plan F is subject to change. For the current deductible, please consult the most current version of the Guide to Health Insurance for People with Medicare, which must be provided by an issuer to an applicant pursuant to NAC 687B.240. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. Benefits from the High Deductible Benefit Plan F will not begin until out-of-pocket expenses are equal to the calendar year deductible. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes, without limitation, the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.*

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

PLAN F or HIGH DEDUCTIBLE PLAN F

OTHER BENEFITS - NOT COVERED BY MEDICARE

***** The High Deductible Benefit Plan F pays the same benefits as the Standardized Benefit Plan F after you have paid a calendar year deductible. The annual deductible for the High Deductible Benefit Plan F is subject to change. For the current deductible, please consult the most current version of the Guide to Health Insurance for People with Medicare, which must be provided by an issuer to an applicant pursuant to NAC 687B.240. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. Benefits from the High Deductible Benefit Plan F will not begin until out-of-pocket expenses are equal to the calendar year deductible. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the*

policy. This includes, without limitation, the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	***MEDICARE PAYS***	***AFTER YOU PAY THE DEDUCTIBLE, PLAN PAYS *******	***IN ADDITION TO THE DEDUCTIBLE, YOU PAY *******
FOREIGN TRAVEL - NOT COVERED BY MEDICARE ***Medically necessary emergency care services beginning during the first 60 days of each trip outside the 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 or HIGH DEDUCTIBLE PLAN G

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

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

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

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

******* The High Deductible Plan G pays the same benefits as the Standardized Benefit Plan G after you have paid a calendar year deductible. Benefits from the High Deductible Plan G will not begin until out-of-pocket expenses are equal to the calendar year deductible. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B Deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.***

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

PLAN G or HIGH DEDUCTIBLE PLAN G

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

SERVICES	*MEDICARE PAYS*	*AFTER YOU PAY THE DEDUCTIBLE, PLAN PAYS ******	*IN ADDITION TO THE DEDUCTIBLE, YOU PAY ******
*SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:*			
First 20 days	*All approved amounts*	*$0*	*$0*
21st thru 100th day	*All but ** a day*	*Up to ** a day*	*$0*
101st day and after	*$0*	*$0*	*All costs*
BLOOD			
First 3 pints	*$0*	*3 pints*	*$0*
Additional amounts	*100%*	*$0*	*$0*
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	*All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care*	*Medicare copayment/coinsurance*	*$0*

PLAN G or HIGH DEDUCTIBLE PLAN G

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

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

*******   The High Deductible Benefit Plan G pays the same benefits as the Standardized Benefit Plan G after you have paid a calendar year deductible. The annual deductible for the High Deductible Benefit Plan G is subject to change. For the current deductible, please consult the most current version of the Guide to Health Insurance for People with Medicare, which must be provided by an issuer to an applicant pursuant to NAC 687B.240. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. Benefits from the High Deductible Benefit Plan G will not begin until out-of-pocket expenses are equal to the calendar year deductible. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B Deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.***

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

SERVICES	MEDICARE PAYS	AFTER YOU PAY THE DEDUCTIBLE, PLAN PAYS ****	IN ADDITION TO THE DEDUCTIBLE, YOU PAY ****
Remainder of Medicare-approved amounts	*Generally 80%*	*Generally 20%*	*$0*
Part B Excess Charges (Above Medicare-approved amounts)	*$0*	*100%*	*$0*
BLOOD			
First 3 pints	*$0*	*All costs*	*$0*
*Next portion of Medicare-approved amounts**	*$0*	*$0*	*(Part B Deductible, unless Part B Deductible has been met)*
Remainder of Medicare-approved amounts	*80%*	*20%*	*$0*
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	*100%*	*$0*	*$0*

PLAN G or HIGH DEDUCTIBLE PLAN G
PARTS A & B

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

*****   The High Deductible Benefit Plan G pays the same benefits as the Standardized Benefit Plan G after you have paid a calendar year deductible. The annual deductible for the High Deductible Benefit Plan G is subject to change. For the current deductible, please consult the most current version of the Guide to Health Insurance for People with Medicare, which must be provided by an issuer to an applicant pursuant to NAC 687B.240. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. Benefits from the High Deductible Benefit Plan G will not begin until out-of-pocket expenses are equal to the calendar year deductible. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B Deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.*

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

PLAN G or HIGH DEDUCTIBLE PLAN G

OTHER BENEFITS - NOT COVERED BY MEDICARE

*****   The High Deductible Benefit Plan G pays the same benefits as the Standardized Benefit Plan G after you have paid a calendar year deductible. The annual deductible for the High Deductible Benefit Plan G is subject to change. For the current deductible, please consult the most current version of the Guide to Health Insurance for People with Medicare, which must be provided by an issuer to an applicant pursuant to NAC 687B.240. The cover page of the outline of coverage which must be provided to an applicant by an issuer pursuant to this section must specify the current amount of the deductible. Benefits from*

the High Deductible Benefit Plan G will not begin until out-of-pocket expenses are equal to the calendar year deductible. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B Deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

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

PLAN K

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

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

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

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but ***	(50% of Part A Deductible)	(50% of Part A Deductible)◆
61st thru 90th day	All but *** a day	*** a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but *** a day	*** a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0****
Beyond the additional 365 days	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but *** a day	Up to 50% of *** a day (50% of Part A Coinsurance)	Up to 50% of *** a day (50% of Part A Coinsurance) ◆
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50%◆
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	50% of coinsurance or copayments	50% of Medicare copayment/coinsurance ◆

PLAN K

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

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

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

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
BLOOD First 3 pints Next portion of Medicare-approved amounts **** Remainder of Medicare-approved amounts	 $0 $0 Generally 80%	 50% $0 Generally 10%	 50%◆ (Part B Deductible) ****◆ Generally 10%◆
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN K

PARTS A & B

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

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

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

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

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

PLAN L

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

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

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

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

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

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

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

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

PLAN L

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

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

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

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

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

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

PLAN L

PARTS A & B

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

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

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

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

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

PLAN M

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

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

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

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

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

PLAN M

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN M

PARTS A & B

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

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

PLAN M

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

PLAN N

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

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

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

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

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

PLAN N

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

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

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

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

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

PLAN N

PARTS A & B

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

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

PLAN N

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

Sec. 15. NAC 687B.322 is hereby amended to read as follows:

687B.322 1. In addition to the standards set forth in NAC 687B.323, the standards provided for in this section are:

(a) ~~[Applicable]~~ ***Except as otherwise provided in section 6 of this regulation, applicable*** to all policies to supplement Medicare or certificates delivered or issued for delivery in this State with an effective date for coverage on or after June 1, 2010; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) A policy to supplement Medicare or a certificate must provide that benefits and premiums under the policy or certificate must be suspended at the request of the policyholder or certificate

holder for the period, not to exceed 24 months, during which the policyholder or certificate holder has applied for and is determined to be eligible for medical assistance under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 et seq., if the policyholder or certificate holder notifies the issuer of the policy or certificate within 90 days after the date the person becomes eligible for such assistance. If benefits or premiums are suspended and the policyholder or certificate holder loses eligibility for such medical assistance, the policy or certificate must be automatically reinstated effective as of the date eligibility is terminated if the policyholder or certificate holder provides notice of loss of eligibility to the insurer within 90 days after the date of loss and pays the premium attributable to the period of eligibility.

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

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

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

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

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

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

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

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

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

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

(e) Coverage for the coinsurance amount, or, in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible

expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

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

4. On or after June 1, 2010, the following additional benefits must be included in Standardized Benefit Plans B, C, D, F, F with High Deductible, G, ***G with High Deductible,*** M and N to supplement Medicare as provided by NAC 687B.323 [:] ***and section 6 of this regulation:***

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

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

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

(d) [Coverage] ***Except as otherwise provided in sections 5 and 6 of this regulation, coverage*** for 100 percent of the Medicare Part B deductible amount per calendar year regardless of hospital confinement;

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

(f) Coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare eligible expenses for medically necessary emergency hospital, physician and medical

care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this paragraph, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

Sec. 16. NAC 687B.323 is hereby amended to read as follows:

687B.323 1. In addition to the standards set forth in NAC 687B.322, the standards provided for in this section are:

(a) ~~[Applicable]~~ ***Except as otherwise provided in section 6 of this regulation, applicable*** to all policies to supplement Medicare or certificates delivered or issued for delivery in this State with an effective date for coverage on or after June 1, 2010; and

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

2. On or after June 1, 2010, an issuer shall make available to each prospective policyholder or certificate holder a policy form or certificate form containing only the basic core benefits, as set forth in subsection 3 of NAC 687B.322.

3. ~~[On]~~ ***Except as otherwise provided in section 6 of this regulation, on*** or after June 1, 2010, if an issuer makes available any of the additional benefits set forth in subsection 4 of NAC 687B.322, or offers Standardized Benefit Plan K or L as described in paragraphs (h) and (i) of subsection 7, the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic core benefits as described in subsection 2, a policy form or certificate form containing either Standardized

Benefit Plan C as described in paragraph (c) of subsection 7 or Standardized Benefit Plan F as described in paragraph (e) of subsection 7.

4. [On] ***Except as otherwise provided in section 6 of this regulation, on*** or after June 1, 2010, no group, package or combinations of benefits to supplement Medicare other than those listed in this section may be offered for sale in this State, except as may be permitted in subsection 8 and in NAC 687B.340 to 687B.376, inclusive.

5. [On] ***Except as otherwise provided in section 6 of this regulation, on*** or after June 1, 2010 [, a] ***:***

(a) A benefit plan must be uniform in structure, language, designation and format to the standardized benefit plans listed in this section and must conform to the definition in NAC 687B.2003 [.] ***or section 2 of this regulation, as applicable;***

(b) Each benefit must be structured in accordance with the format provided in subsections 3 and 4 of NAC 687B.322 or, in the case of Standardized Benefit Plan K or L, in paragraphs (h) and (i) of subsection 7, and list the benefits in the order shown in the applicable requirements.

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

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

(a) A 2010 standardized benefit plan to supplement Medicare ***, or a 2020 standardized benefit plan to supplement Medicare,*** which is designated as Standardized Benefit Plan A must include only the basic core benefits as defined in subsection 3 of NAC 687B.322.

(b) A 2010 standardized benefit plan to supplement Medicare ***, or a 2020 standardized benefit plan to supplement Medicare,*** which is designated as Standardized Benefit Plan B must include only the basic core benefits as defined in subsection 3 of NAC 687B.322, plus 100

percent of the Medicare Part A deductible as defined in paragraph (a) of subsection 4 of NAC 687B.322.

(c) A 2010 standardized benefit plan to supplement Medicare which is designated as Standardized Benefit Plan C must include only the basic core benefits as defined in subsection 3 of NAC 687B.322, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in paragraphs (a), (c), (d) and (f) of subsection 4 of NAC 687B.322, respectively. ***A Standardized Benefit Plan C is not available for a 2020 standardized benefit plan to supplement Medicare.***

(d) A 2010 standardized benefit plan to supplement Medicare ***, or a 2020 standardized benefit plan to supplement Medicare,*** which is designated as Standardized Benefit Plan D must include only the basic core benefits as defined in subsection 3 of NAC 687B.322, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs (a), (c) and (f) of subsection 4 of NAC 687B.322, respectively.

(e) A 2010 standardized benefit plan to supplement Medicare which is designated as Standardized Benefit Plan F must include only the basic core benefits as defined in subsection 3 of NAC 687B.322, plus 100 percent of the Medicare Part A deductible, the skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (a), (c), (d), (e) and (f) of subsection 4 of NAC 687B.322, respectively. ***A Standardized Benefit Plan F is not available for a 2020 standardized benefit plan to supplement Medicare.***

(f) A 2010 standardized benefit plan to supplement Medicare***, or, except as otherwise provided in section 6 of this regulation, a 2020 standardized benefit plan to supplement Medicare,*** which is designated as High Deductible Benefit Plan F:

(1) Must include only 100 percent of covered expenses following the payment of the annual deductible set forth in subparagraph (2) and the basic core benefits as defined in subsection 3 of NAC 687B.322, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (a), (c), (d), (e) and (f) of subsection 4 of NAC 687B.322, respectively; and

(2) Has an annual deductible that:

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

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

(III) Has a base which must be $1,500 and must be adjusted annually from 1999 by the Secretary of the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

(g) A 2010 standardized benefit plan to supplement Medicare ***, or a 2020 standardized benefit plan to supplement Medicare,*** which is designated as Standardized Benefit Plan G must include only the basic core benefits as defined in subsection 3 of NAC 687B.322, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (a), (c), (e) and (f) of subsection 4 of NAC 687B.322, respectively.

(h) A 2010 standardized benefit plan to supplement Medicare ***, or a 2020 standardized benefit plan to supplement Medicare,*** which is designated as Standardized Benefit Plan K is mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, 117 Stat. 2066, December 8, 2003, and must include:

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

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

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

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

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

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

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

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

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

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

(i) A 2010 standardized benefit plan to supplement Medicare ***, or a 2020 standardized benefit plan to supplement Medicare,*** which is designated as Standardized Benefit Plan L is mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, 117 Stat. 2066, December 8, 2003, and must include only the following:

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

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

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

(j) A 2010 standardized benefit plan to supplement Medicare ***, or a 2020 standardized benefit plan to supplement Medicare,*** which is designated as Standardized Benefit Plan M must include only the basic core benefits as defined in subsection 3 of NAC 687B.322, plus 50 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs (b), (c) and (f) of subsection 4 of NAC 687B.322, respectively.

(k) A 2010 standardized benefit plan to supplement Medicare ***, or a 2020 standardized benefit plan to supplement Medicare,*** which is designated as Standardized Benefit Plan N must include only the basic core benefits as defined in subsection 3 of NAC 687B.322, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care and medically necessary emergency care in a foreign country as defined in paragraphs (a), (c) and (f) of subsection 4 of NAC 687B.322, respectively, with coinsurance or copayments in the following amounts:

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

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

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

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

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

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

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

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