20:06:12:07. Guidelines for examination reports. The insurer's examination report ~~shall~~ must be prepared in accordance with standards adopted by the National Association of Insurance Commissioners in the Financial Condition Examiners Handbook, ~~2019~~ 2020 edition.

Source: 21 SDR 144, effective February 19, 1995; 23 SDR 43, effective October 1, 1996; 23 SDR 202, effective June 1, 1997; 25 SDR 13, effective August 9, 1998; 26 SDR 26, effective September 1, 1999; 27 SDR 54, effective December 4, 2000; 29 SDR 84, effective December 15, 2002; 31 SDR 21, effective August 23, 2004; 33 SDR 59, effective October 5, 2006; 34 SDR 271, effective May 6, 2008; 35 SDR 165, effective December 22, 2008; 36 SDR 209, effective July 1, 2010; 37 SDR 241, effective July 1, 2011; 38 SDR 219, effective June 25, 2012; 39 SDR 219, effective June 26, 2013; 41 SDR 41, effective September 17, 2014; 42 SDR 52, effective October 13, 2015; 42 SDR 177, effective June 28, 2016; 43 SDR 181, effective July 7, 2017; 45 SDR 10, effective August 2, 2018; 46 SDR 26, effective September 4, 2019.

General Authority: SDCL 58-3-11, 58-3-26.

Law Implemented: SDCL 58-3-11.

Reference: Financial Condition Examiners Handbook, ~~2019~~ 2020 edition, National Association of Insurance Commissioners. Copies may be obtained from the NAIC, 1100 Walnut Street, Ste. 1500, Kansas City, MO 64106-2197, (816) 783-8300. Cost: ~~$250~~ $295.

20:06:13:17.16. Standard Medicare supplement benefit plans for ~~2010~~ 2020 standardized Medicare supplement benefit plan policies or certificates issued for delivery to individuals newly eligible for Medicare after December 31, 2019. No policy or certificate that provides coverage for the Medicare Part B deductible may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate to individuals newly

eligible for Medicare after December 31, 2019. ~~All policies must comply with the following benefit standards.~~

~~The~~ An individual who, after December 31, 2019, becomes newly eligible for Medicare upon reaching the age of 65, becomes newly entitled to benefits under Medicare Part A pursuant to section 226(b) or 226A of the Social Security Act, or becomes newly eligible for benefits under section 226(a) of the Social Security Act may only be offered, delivered, or issued for delivery in this state a Medicare supplement policy or certificate that complies with the standards and requirements of §§ 20:06:13:17.14 and 20:06:13:17.15 ~~shall apply to all Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare after December 31, 2019~~, with the following exceptions:

(1) Standardized Medicare supplement benefit Plan C is redesignated as Plan D and ~~shall~~ must provide the benefits contained in subdivision 20:06:13:17:15(3) ~~but shall not provide~~ except coverage for ~~one hundred percent (100%) or~~ any portion of the Medicare Part B deductible;

(2) Standardized Medicare supplement benefit Plan F is redesignated as Plan G and ~~shall~~ must provide the benefits contained in subdivision 20:06:13:17:15 ~~(5) but shall not provide~~ except coverage for ~~one hundred percent (100%) or~~ any portion of the Medicare Part B deductible;

(3) Standardized Medicare supplement benefit plans C, F, and F with High Deductible may not be offered to individuals newly eligible for Medicare after December 31, 2019; ~~and~~

(4) Standardized Medicare supplement benefit Plan F With High Deductible is redesignated as Plan G With High Deductible and ~~shall~~ must provide the benefits contained in subdivision 20:06:13:17:15(6), ~~but shall not provide coverage for one hundred percent (100%) or~~

~~any portion of~~ except coverage for the Medicare Part B deductible~~, provided further that~~, and the Medicare Part B deductible paid by the beneficiary ~~shall~~ must be considered an out-of-pocket expense in meeting the annual high deductible~~.~~; and

(5) The reference to Plans C or F contained in § 20:06:13:17.14 is ~~deemed~~ a reference to Plans D or G ~~for purposes of this section~~.

~~This section applies to only individuals that are newly eligible for Medicare after December 31, 2019, by reason of:~~

~~(1) Attaining age 65 after December 31, 2019; or~~

~~(2) By reason of entitlement to benefits under part A pursuant to section 226(b) or 226A of the Social Security Act, or who is deemed to be eligible for benefits under section 226(a) of the Social Security Act on or after January 1, 2020.~~

~~For purposes of 20:06:13:81, in the case of any individual newly eligible for Medicare after December 31, 2019, any reference to a Medicare supplement policy C or F, including F With High Deductible, shall be deemed to be a reference to Medicare supplement policy D or G, including G With High Deductible.~~

After December 31, 2019, the standardized benefit plans described above may be offered to any individual who was eligible for Medicare on or prior to January 1, 2020 in addition to the standardized plans described in 20:06:13:17.15.

Source: 44 SDR 184, effective June 25, 2018.

General Authority: SDCL 58-17A-2.

Law Implemented: SDCL 58-17A-2.

20:06:13:81. Guaranteed issue -- Products to which eligible persons are entitled. The Medicare supplement policies to which an eligible person is entitled are as follows:

(1) A person eligible under subdivisions 20:06:13:80(1), (2), (3), or (4) is entitled to a Plan A, B, C, F, F with high deductible, K, or L Medicare supplement policy offered by an issuer;

(2) A person eligible under subdivision 20:06:13:80(5) is entitled to the same Medicare supplement policy in which the individual was most recently enrolled, if available from the same issuer, or, if not available, a policy described in subdivision (1) of this section. After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in this subdivision 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, F with high deductible, K, or L policy that is offered by any issuer;

(3) A person eligible under subdivision 20:06:13:80(6) is entitled to any Medicare supplement policy offered by an issuer;

(4) A person eligible under subdivision 20:06:13:80(7) is entitled to a Plan A, B, C, F, F with high deductible, K, or L that is offered and available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.

For purposes of 20:06:13:81, in the case of any individual newly eligible for Medicare after December 31, 2019, any reference to a Medicare supplement policy C or F, including F

With High Deductible, shall be deemed to be a reference to Medicare supplement policy D or G, including G With High Deductible.

Source: 25 SDR 44, effective September 30, 1998; 31 SDR 214, effective July 6, 2005; 36 SDR 209, effective July 1, 2010.

General Authority: SDCL 58-17A-2(2)(16).

Law Implemented: SDCL 58-17A-2(2)(16).

DEPARTMENT OF LABOR AND REGULATION

DIVISION OF INSURANCE

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE POLICIES PLANS A THROUGH N

Chapter 20:06:13

APPENDIX D

SEE: § 20:06:13:36

Source: 18 SDR 225, effective July 17, 1992; 23 SDR 236, effective July 13, 1997; 25 SDR 44, effective September 30, 1998; 26 SDR 26, effective September 1, 1999; 27 SDR 53, effective December 4, 2000; 31 SDR 214, effective July 6, 2005; 35 SDR 83, effective February 2, 2009; 36 SDR 209, effective July 1, 2010; 37 SDR 241, effective July 1, 2011; 39 SDR 10, effective August 1, 2012; 41 SDR 41, effective September 17, 2014; 42 SDR 52, effective October 13, 2015; 42 SDR 177, effective June 28, 2016; 43 SDR 181, effective July 7, 2017; 44 SDR 184, effective June 25, 2018.

APPENDIX D

[COMPANY NAME]

Outline of Medicare Supplement Coverage-Cover Page:

Benefit Plan(s)_____[insert letter(s) of plan(s) being offered]

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan A. Some plans may not be available in your state.

See Outlines of Coverage sections for details about ALL plans.

Basic Benefits:

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

Medical Expenses -- Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. 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
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
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible
		Part 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

K	L	M	N
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 $20 copayment for office visit, and up to $50 copayment for ER
50% Skilled Nursing Facility Coinsurance 50% Part A Deductible	75% Skilled Nursing Facility Coinsurance 75% Part A Deductible	Skilled Nursing Facility Coinsurance 50% Part A Deductible	Skilled Nursing Facility Coinsurance Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit $[~~5240~~ 5,880]; paid at 100% after limit reached	Out-of-pocket limit $[~~2620~~ 2,940]; 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 ~~$2,240~~ $2,340 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed ~~$2,240~~ $2,340. 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.

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.]

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 itself 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 health insurance policy, 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 fully 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, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this chapter. An issuer may use additional benefit plan designations on these charts pursuant to § 20:06:13:17.05.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the director.]

Benefit Chart of Medicare Supplement Plans Sold ~~after December 31, 2019~~ 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 in [~~2018~~ 2020][2]					**[~~$5,240~~ $5,880][2]**	**[~~$2,620~~ $2,940][2]**				

1 Plans F and G also have a high deductible option which require first paying a plan deductible of [~~$2,240~~ $2,340] 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 co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[~~1340~~ 1,408]	$0	$[~~1340~~ 1,408] (Part A deductible)
61st thru 90th day	All but $[~~335~~ 352] a day	$[~~335~~ 352] a day	$0
91st day and after:			
--While using 60 lifetime reserve days		$[~~670~~ 704] a day	$0
--Once lifetime reserve days are used:			
--Additional 365 days	All but $[~~670~~ 704] a day	100% of Medicare eligible expenses	$0**
--Beyond the additional 365 days	$0	$0	All costs
	$0		
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 $[~~167.50~~ 176] a day	$0	Up to $[~~167.50~~ 176] a day
101st day and after	$0	$0	All costs
BLOOD	$0		
First 3 pints	100%	3 pints	$0
Additional amounts		$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 out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****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 on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

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

*Once you have been billed $[~~183~~ 198] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[~~183~~ 198] of Medicare approved amounts* Remainder of Medicare approved amounts	 $0 Generally 80%	 $0 Generally 20%	 $[~~183~~ 198] (Part B deductible) $0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints Next $[~~183~~ 198] of Medicare approved amounts* Remainder of Medicare approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 $[~~183~~ 198] (Part B deductible) $0
CLINICAL LABORATORY SERVICES --TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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 $[~~183~~ 198] of Medicare approved amounts* Remainder of Medicare approved amounts	 100% $0 80%	 $0 $0 20%	 $0 $[~~183~~ 198] (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 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[~~1340~~ 1,408]	$[~~1340~~ 1,408] (Part A deductible)	$0
61st thru 90th day	All but $[~~335~~ 352] a day	$[~~335~~ 352] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[~~670~~ 704] a day	$[~~670~~ 704] 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 $[~~167.50~~ 176] a day	$0	Up to $[~~167.50~~ 176] 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 out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

** **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 on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

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

*Once you have been billed $[~~183~~ 198] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[~~183~~ 198] of Medicare approved amounts* Remainder of Medicare approved amounts	 $0 Generally 80%	 $0 Generally 20%	 $[~~183~~ 198] (Part B deductible) $0
Part B Excess Charges (Above Medicare Approved Amounts	$0	$0	All costs
BLOOD First 3 pints Next $[~~183~~ 198] of Medicare approved amounts* Remainder of Medicare approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 $[~~183~~ 198] (Part B deductible) $0
CLINICAL LABORATORY SERVICES --TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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 $[~~183~~ 198] of Medicare approved amounts* Remainder of Medicare approved amounts	 100% $0 80%	 $0 $0 20%	 $0 $[~~183~~ 198] (Part B deductible) $0

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[~~1340~~ 1,408]	$[~~1340~~ 1,408] (Part A deductible)	$0
61st thru 90th day	All but $[~~335~~ 352] a day	$[~~335~~ 352] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[~~670~~ 704] a day	$[~~670~~ 704] 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 $[~~167.50~~ 176] a day	Up to $[~~167.50~~ 176] 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 out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****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 on any difference between its billed charges and the amount Medicare would have paid.

PLAN C

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

*Once you have been billed $[~~183~~ 198] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[~~183~~ 198] of Medicare approved amounts*	$0	$[~~183~~ 198] (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 $[~~183~~ 198] of Medicare approved amounts*	$0	$[~~183~~ 198] (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES --TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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 $[~~183~~ 198] of Medicare approved amounts*	$0 80%	$[~~183~~ 198] (Part B deductible) 20%	$0 $0
Remainder of Medicare approved amounts			

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 USA			
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 life-time maximum

PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[~~1,340~~ 1,408]	$[~~1340~~ 1,408] (Part A deductible)	$0
61st thru 90th day	All but $[~~335~~ 352] a day	$[~~335~~ 352] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[~~670~~ 704] a day	$[~~670~~ 704] 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 $[~~167.50~~ 176] a day	Up to $[~~167.50~~ 176] 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 out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****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 on any difference between its billed charges and the amount Medicare would have paid.

PLAN D

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

*Once you have been billed $[~~183~~ 198] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[~~183~~ 198] of Medicare approved amounts* Remainder of Medicare approved amounts	 $0 Generally 80%	 $0 Generally 20%	 $[~~183~~ 198] (Part B deductible) $0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints Next $[~~183~~ 198] of Medicare approved amounts* Remainder of Medicare approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 $[~~183~~ 198] (Part B deductible) $0
CLINICAL LABORATORY SERVICES --TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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 $[~~183~~ 198] of Medicare approved amounts* Remainder of Medicare approved amounts	 100% $0 80%	 $0 $0 20%	 $0 $[~~183~~ 198] (Part B deductible) $0

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 USA 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 life-time 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 days in a row.
**This high deductible plan pays the same benefits as Plan F after you have paid a calendar year $[~~2,240~~ 2,340] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $[~~2,240~~ 2,340]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[~~2,240~~ 2,340] DEDUCTIBLE,** PLAN PAYS]	[IN ADDITION TO $[~~2,240~~ 2,340] DEDUCTIBLE,** YOU PAY]
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[~~1,340~~ 1,408]	$[~~1340~~ 1,408] (Part A deductible)	$0
61st thru 90th day	All but $[~~335~~ 352] a day	$[~~335~~ 352] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[~~670~~ 704] a day	$[~~670~~ 704] 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 $[~~167.50~~ 176] a day	Up to $[~~167.50~~ 176] 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 out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****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 on any difference between its billed charges and the amount Medicare would have paid.

PLAN F or HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed $[~~183~~ 198] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.
**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $[~~2,240~~ 2,340] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $[~~2,240~~ 2,340]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[~~2,240~~ 2,340] DEDUCTIBLE,** PLAN PAYS]	[IN ADDITION TO $[~~2,240~~ 2,340] 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 $[~~183~~ 198] of Medicare approved amounts* Remainder of Medicare approved amounts	 $0 Generally 80%	 $[~~183~~ 198] (Part B deductible) Generally 20%	 $0 $0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints Next $[~~183~~ 198] of Medicare approved amounts* Remainder of Medicare approved amounts	 $0 $0 80%	 All costs $[~~183~~ 198] (Part B deductible) 20%	 $0 $0 $0
CLINICAL LABORATORY SERVICES --TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[~~2,240~~ 2,340] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[~~2,240~~ 2,340] DEDUCTIBLE,**] YOU PAY'
HOME HEALTH CARE MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies ---Durable medical equipment ---First $[~~183~~ 198] amounts* Remainder of Medicare approved amounts	 100% $0 80%	 $0 $[~~183~~ 198] (Part B deductible) 20%	 $0 $0 $0

(continued)

PLAN F or HIGH DEDUCTIBLE PLAN F (continued)

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[~~2,240~~ 2,340] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[~~2,240~~ 2,340] 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 USA			
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 life-time 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 days in a row.
[**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year [~~$2,240~~ $2,340] deductible.
Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are [~~$2,240~~ $2,340]. 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 $[~~2,240~~ 2,340] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[~~2,240~~ 2,340] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[~~1,340~~ 1,408]	$[~~1340~~ 1,408] (Part A deductible)	$0
61st thru 90th day	All but $[~~335~~ 352] a day	$[~~335~~ 352] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[~~670~~ 704] a day	$[~~670~~ 704] 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 $[~~167.50~~ 176] a day	Up to $[~~167.50~~ 176] a day	$0
101th 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 out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****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 on any difference between its billed charges and the amount Medicare would have paid.

PLAN G or HIGH DEDUCTIBLE PLAN G

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

*Once you have been billed $[~~183~~ 198] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.
[**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year [~~$2,240~~ $2,340] deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are [~~$2,240~~ $2,340]. 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 $[~~2,240~~ 2,340] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[~~2,240~~ 2,340] 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 $[~~183~~ 198] of Medicare approved amounts*	$0	$0	$[~~183~~ 198] (Unless Part B deductible has been met)
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 $[~~183~~ 198] of Medicare approved amounts*	$0	$0	$[~~183~~ 198] (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

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[~~2,240~~ 2,340] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[~~2,240~~ 2,340] DEDUCTIBLE,**] YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
---Medically necessary skilled care services and medical supplies	100%	$0	$0
---Durable medical equipment			
First $[~~183~~ 198] of Medicare approved amounts*	$0	$0	$[~~183~~ 198] (Unless Part B deductible has been met)
Remainder of Medicare approved amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[~~2,240~~ 2,340] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[~~2,240~~ 2,340] 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 USA			
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 life-time maximum

PLAN K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[~~5,240~~ 5,880] each calendar year. The amounts that count toward your annual limit are noted with diamonds(♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for that item or service.**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[~~1,340~~ 1,408]	$[~~670~~ 704] (50% of Part A deductible)	$[~~670~~ 704] (50% of Part A deductible)♦
61st thru 90th day	All but $[~~335~~ 352] a day	$[~~335~~ 352] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[~~670~~ 704] a day	$[~~670~~ 704] 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 $[~~167.50~~ 176] a day	Up to $[~~83.75~~ 88] a day (50% of Part A coinsurance)	Up to $[~~83.75~~ 88] 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/copayment	50% of Medicare copayment/coinsurance♦

***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 on any difference between its billed charges and the amount Medicare would have paid.

PLAN K

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

****Once you have been billed $[~~183~~ 198] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $[~~183~~ 198] of Medicare approved amounts**** Preventative Benefits for Medicare covered services Remainder of Medicare approved amounts	$0 Generally 80% or more of Medicare approved amounts Generally 80%	$0 Remainder of Medicare approved amounts Generally 10%	$[~~183~~ 198] (Part B deductible)****♦ All costs above Medicare approved amounts 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 of $[~~5,240~~ 5,880])*
BLOOD First 3 pints Next $[~~183~~ 198] of Medicare approved amounts**** Remainder of Medicare approved amounts	$0 $0 Generally 80%	50% $0 Generally 10%	$50%♦ $[~~183~~ 198] (Part B deductible)****♦ Generally 10%♦
CLINICAL LABORATORY SERVICES --TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[~~5,240~~ 5,880] 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.**

PARTS A & B

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 $[~~183~~ 198] of Medicare approved amounts ***** Remainder of Medicare approved amounts	100% $0 80%	$0 $0 10%	$0 $[~~183~~ 198] (Part B deductible)♦ 10%♦

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

PLAN L

*You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[~~2,620~~ 2,940] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for that item or service.**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[~~1,340~~ 1,408]	$[~~1,005~~ 1,056] (75% of Part A deductible)	$[~~335~~ 352] (25% of Part A deductible)♦
61st thru 90th day	All but $[~~335~~ 352] a day	$[~~335~~ 352] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[~~670~~ 704] a day	$[~~670~~ 704] 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 $[~~167.50~~ 176] a day	Up to $[~~125.63~~ 132] a day (75% of Part A Coinsurance)	Up to $[~~41.88~~ 44] a day (25% of Part A Coinsurance)♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	75%	25%♦
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	75% of copayment/coinsurance	25% of copayment/coinsurance ♦

***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 on any difference between its billed charges and the amount Medicare would have paid.

PLAN L

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

****Once you have been billed $[~~183~~ 198] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $[~~183~~ 198] of Medicare approved amounts**** Preventative Benefits for Medicare covered services Remainder of Medicare approved amounts	$0 Generally 80% or more of Medicare approved amounts Generally 80%	$0 Remainder of Medicare approved amounts Generally 15%	$[~~183~~ 198] (Part B deductible)****♦ All costs above Medicare approved amounts 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 of $[~~2,620~~ 2,940])*
BLOOD First 3 pints Next $[~~183~~ 198] of Medicare approved amounts**** Remainder of Medicare approved amounts	$0 $0 Generally 80%	75% $0 Generally 15%	$25% $[~~183~~ 198] (Part B deductible)****♦ Generally 5%♦
CLINICAL LABORATORY SERVICES --TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[~~2620~~ 2,940] 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.**

PARTS A & B

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 $[~~183~~ 198] of Medicare approved amounts ***** Remainder of Medicare approved amounts	100% $0 80%	$0 $0 15%	$0 $[~~183~~ 198] (Part B deductible)♦ 5%♦

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

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 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[~~1,340~~ 1,408]	$[~~670~~ 704] (50% of Part A deductible)	$[~~670~~ 704] (50% of Part A deductible)
61st thru 90th day	All but $[~~335~~ 352] a day	$[~~335~~ 352] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[~~670~~ 704] a day	$[~~670~~ 704] 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 $[~~167.50~~ 176] a day	Up to $[~~167.50~~ 176] 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

****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.

PLAN M

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

*Once you have been billed $[~~183~~ 198] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[~~183~~ 198] of Medicare approved amounts*	$0	$0	$[~~183~~ 198] (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 $[~~183~~ 198] of Medicare approved amounts*	$0	$0	$[~~183~~ 198] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	0%
CLINICAL LABORATORY SERVICES --TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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 $[~~183~~ 198] of Medicare approved amounts *	$0	$0	$[~~183~~ 198] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0

OTHER BENEFITS -- NOT COVERED BY MEDICARE

FOREIGN TRAVEL NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
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 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[~~1,340~~ 1,408]	$[~~1,340~~ 1,408] (Part A	$0
61st thru 90th day	All but $[~~335~~ 352] a day	deductible)	$0
91st day and after:		$[~~335~~ 352] a day	
--While using 60 lifetime reserve days	All but $[~~670~~ 704] a day	$[~~670~~ 704] a day	$0
--Once lifetime reserve days are used:			
--Additional 365 days	$0		$0**
--Beyond the additional 365 days	$0	100% of Medicare eligible expenses $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 $[~~167.50~~ 176] a day	Up to $[~~167.50~~ 176] 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

****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.

PLAN N

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

*Once you have been billed $[~~183~~ 198] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $[~~183~~ 198] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 Generally 80%	$0 Balance, other than up to [$20] per office visit and up to [$50] per emergency room visit. The copayment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense	$[~~183~~ 198] (Part B deductible) Up to [$20] per office visit and up to [$50] per emergency room visit. The copayment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints Next $[~~183~~ 198] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 $0 80%	All costs $0 20%	$0% $[~~183~~ 198] (Part B deductible) 0%
CLINICAL LABORATORY SERVICES --TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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 $[~~183~~ 198] of Medicare approved amounts* Remainder of Medicare approved amounts	100% $0 80%	$0 $0 20%	$0 $[~~183~~ 198] (Part B deductible) $0

OTHER BENEFITS -- NOT COVERED BY MEDICARE

FOREIGN TRAVEL NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
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

20:06:19:04. Accounting standards for transactions in exchange-traded call and put options. An insurance company that buys or sells exchange-traded call and put options must record the details of the transactions in a manner consistent with NAIC rules and procedures contained in the ~~2018~~ 2019 edition of the **Annual Statement Instructions**, the ~~2019~~ 2020 edition of the **Financial Condition Examiners Handbook**, the ~~2019~~ 2020 edition of the **Accounting Practices and Procedures Manual**, and the ~~2018~~ 2019 edition of the **Purposes and Procedures Manual of the NAIC Investment Analysis Office**.

Source: 13 SDR 75, effective December 21, 1986; 22 SDR 110, effective March 1, 1996; 23 SDR 43, effective October 1, 1996; 25 SDR 13, effective August 9, 1998; 26 SDR 26, effective September 1, 1999; 27 SDR 54, effective December 4, 2000; 27 SDR 111, effective May 7, 2001; 30 SDR 39, effective September 28, 2003; 33 SDR 59, effective October 5, 2006; 34 SDR 271, effective May 6, 2008; 35 SDR 165, effective December 22, 2008; 36 SDR 209, effective July 1, 2010; 37 SDR 241, effective July 1, 2011; 38 SDR 219, effective June 25, 2012; 39 SDR 219, effective June 26, 2013; 41 SDR 41, effective September 17, 2014; 42 SDR 52, effective October 13, 2015; 42 SDR 177, effective June 28, 2016; 43 SDR 181, effective July 7, 2017; 45 SDR 10, effective August 2, 2018; 46 SDR 26, effective September 4, 2019.

General Authority: SDCL 58-27-7.

Law Implemented: SDCL 58-27-7.

References:

1. **Annual Statement Instructions - Life, Accident and Health**, ~~2018~~ 2019 edition, National Association of Insurance Commissioners. Cost: ~~$200~~ $250.

2. **Annual Statement Instructions - Property and Casualty**, ~~2018~~ 2019 edition, National Association of Insurance Commissioners. Cost: ~~$200~~ $250.

3. **Accounting Practices and Procedures Manual**, ~~2019~~ 2020 edition, National Association of Insurance Commissioners. Cost: Hard Copy, $465~~; CD ROM $395~~.

4. **Financial Condition Examiners Handbook**, ~~2019~~ 2020 edition, National Association of Insurance Commissioners. Cost: ~~$250~~ $295.

5. **Purposes and Procedures Manual of the NAIC Investment Analysis Office**, ~~2018~~ 2019 edition, National Association of Insurance Commissioners. Cost: ~~$50~~ $75.

Copies of references 1 ~~to~~ through 5~~, inclusive,~~ may be obtained from the National Association of Insurance Commissioners, 1100 Walnut Street, Ste. 1500, Kansas City, MO 64106-2197, (816) 783-8300; http://www.naic.org.

20:06:25:01. Annual statements. The insurer's annual statement ~~shall~~ must be filed in accordance with the standards adopted by the National Association of Insurance Commissioners in the ~~2019~~ 2020 editions of the **Accounting Practices and Procedures Manual**, and the ~~2018~~ 2019 editions of the **Annual Statement Instructions** manuals for **Life, Accident, and Health**, **Property and Casualty**, **Health**, and **Title**.

Source: 21 SDR 144, effective February 19, 1995; 22 SDR 110, effective March 1, 1996; 23 SDR 202, effective June 1, 1997; 25 SDR 13, effective August 9, 1998; 26 SDR 26, effective September 1, 1999; 27 SDR 54, effective December 4, 2000; 27 SDR 111, effective May 7, 2001; 30 SDR 39, effective September 28, 2003; 31 SDR 21, effective August 23, 2004; 33 SDR 59, effective October 5, 2006; 34 SDR 271, effective May 6, 2008; 35 SDR 165, effective December 22, 2008; 36 SDR 209, effective July 1, 2010; 37 SDR 241, effective July 1, 2011; 38 SDR 219, effective June 25, 2012; 39 SDR 219, effective June 26, 2013; 41 SDR 41, effective September 17, 2014; 42 SDR 52, effective October 13, 2015; 42 SDR 177, effective June 28,

2016; 43 SDR 181, effective July 7, 2017; 45 SDR 10, effective August 2, 2018; 46 SDR 26, effective September 4, 2019.

General Authority: SDCL 58-6-75.

Law Implemented: SDCL 58-6-75.

References:

1. **Annual Statement Instructions - Life, Accident, and Health**, ~~2018~~ 2019 edition. Cost: ~~$200~~ $250.

2. **Annual Statement Instructions - Property and Casualty**, ~~2018~~ 2019 edition. Cost: ~~$200~~ $250.

3. **Annual Statement Instructions - Health**, ~~2018~~ 2019 edition. Cost: ~~$200~~ $250.

4. **Annual Statement Instructions - Title**, ~~2018~~ 2019 edition. Cost: ~~$200~~ $250.

5. **Accounting Practices and Procedures Manual**, ~~2019~~ 2020. Cost: Hard Copy, $465~~;~~ ~~CD ROM, $395~~.

Copies of references 1 ~~to~~ through 5~~, inclusive,~~ may be obtained from the National Association of Insurance Commissioners, 1100 Walnut Street, Ste. 1500, Kansas City, MO 64106-2197, (816) 783-8300; http://www.naic.org.

20:06:25:01.01. Accounting methods for certain surety bonds. Insurers writing surety bonds guaranteeing to lending institutions the repayment of student loans made by lending institutions may, in lieu of compliance with SSAP60 of the **Accounting Practices and Procedures Manual**, develop premium earning patterns that are representative of their claims and expense patterns by loan and program, and compute unearned premium reserves according to those premium earning patterns. In lieu of compliance with SSAP3 of the **Accounting Practices and Procedures Manual**, changes in accounting estimates, for this method of

accounting only, may be amortized over the remaining life of the student loans utilizing pro-rated current premium earning patterns. In lieu of compliance with SSAP53 of the **Accounting Practices and Procedures Manual,** such insurers may recognize written premiums when due.

Source: 27 SDR 111, effective May 7, 2001; 29 SDR 5, effective July 10, 2002; 30 SDR 39, effective September 28, 2003; 31 SDR 21, effective August 23, 2004; 33 SDR 59, effective October 5, 2006; 34 SDR 271, effective May 6, 2008; 35 SDR 165, effective December 22, 2008; 36 SDR 209, effective July 1, 2010; 37 SDR 241, effective July 1, 2011; 38 SDR 219, effective June 25, 2012; 39 SDR 219, effective June 26, 2013; 41 SDR 41, effective September 17, 2014; 42 SDR 52, effective October 13, 2015; 42 SDR 177, effective June 28, 2016; 45 SDR 10, effective August 2, 2018; 46 SDR 26, effective September 4, 2019.

General Authority: SDCL 58-6-75.

Law Implemented: SDCL 58-6-75.

Reference: Accounting Practices and Procedures Manual, ~~2019~~ 2020 edition. Copies may be obtained from the National Association of Insurance Commissioners, 1100 Walnut Street, Ste. 1500, Kansas City, MO 64106-2197, (816) 783-8300; http://www.naic.org. Cost: Hard Copy, $465~~; CD ROM, $395~~.

20:06:25:01.02. Accounting methods for bail bonds. Insurers writing bail bonds may, in lieu of compliance with SSAP 53 of the **Accounting Practices and Procedures Manual**, report bail bond written premiums less agent commissions and may recognize total premiums as earned on the effective date of the bonds. Insurers reporting premiums on this method must file a supplemental Schedule T with their annual statement setting forth the gross premiums by state for premium tax purposes.

Source: 29 SDR 5, effective July 10, 2002; 30 SDR 39, effective September 28, 2003; 31 SDR 21, effective August 23, 2004; 33 SDR 59, effective October 5, 2006; 34 SDR 271, effective May 6, 2008; 35 SDR 165, effective December 22, 2008; 36 SDR 209, effective July 1, 2010; 37 SDR 241, effective July 1, 2011; 38 SDR 219, effective June 25, 2012; 39 SDR 219, effective June 26, 2013; 41 SDR 41, effective September 17, 2014; 42 SDR 52, effective October 13, 2015; 42 SDR 177, effective June 28, 2016; 45 SDR 10, effective August 2, 2018; 46 SDR 26, effective September 4, 2019.

General Authority: SDCL 58-6-75.

Law Implemented: SDCL 58-6-75.

Reference: Accounting Practices and Procedures Manual, ~~2019~~ 2020 edition. Copies may be obtained from the National Association of Insurance Commissioners, 1100 Walnut Street, Ste. 1500, Kansas City, MO 64106-2197, (816) 783-8300; http://www.naic.org. Cost: Hard Copy, $465~~; CD ROM, $395~~.

20:06:25:02. Actuarial opinions. Actuarial opinions shall be filed in accordance with standards adopted by the National Association of Insurance Commissioners in the manuals on **Annual Statement Instructions - Life, Accident, and Health**, ~~2018~~ 2019 edition and **Annual Statement Instructions - Property and Casualty**, ~~2018~~ 2019 edition.

Source: 21 SDR 144, effective February 19, 1995; 22 SDR 110, effective March 1, 1996; 23 SDR 202, effective June 1, 1997; 25 SDR 13, effective August 9, 1998; 26 SDR 26, effective September 1, 1999; 27 SDR 54, effective December 4, 2000; 30 SDR 39, effective September 28, 2003; 31 SDR 21, effective August 23, 2004; 33 SDR 59, effective October 5, 2006; 34 SDR 271, effective May 6, 2008; 35 SDR 165, effective December 22, 2008; 36 SDR 209, effective July 1, 2010; 37 SDR 241, effective July 1, 2011; 38 SDR 219, effective June 25, 2012; 39 SDR

219, effective June 26, 2013; 41 SDR 41, effective September 17, 2014; 42 SDR 52, effective October 13, 2015; 42 SDR 177, effective June 28, 2016; 43 SDR 181, effective July 7, 2017; 45 SDR 10, effective August 2, 2018; 46 SDR 26, effective September 4, 2019.

General Authority: SDCL 58-26-13.1, 58-26-46.

Law Implemented: SDCL 58-26-13.1, 58-26-46.

References:

1. **Annual Statement Instructions - Life, Accident, and Health**, ~~2018~~ 2019 edition. Cost: ~~$200~~ $250.

2. **Annual Statement Instructions - Property and Casualty**, ~~2018~~ 2019 edition. Cost: ~~$200~~ $250.

Copies of references 1 and 2 may be obtained from the National Association of Insurance Commissioners, 1100 Walnut Street, Ste. 1500, Kansas City, MO 64106-2197, (816) 783-8300; http://www.naic.org.

20:06:26:01. Standards for rating and valuation of investments. The standards of the division for purposes of rating and valuing investments are the standards set forth in the **Purposes and Procedures Manual of the NAIC Investment Analysis Office of the National Association of Insurance Commissioners**, ~~2018~~ 2019 edition.

Source: 21 SDR 144, effective February 19, 1995; 22 SDR 110, effective March 1, 1996; 23 SDR 202, effective June 1, 1997; 25 SDR 13, effective August 9, 1998; 26 SDR 26, effective September 1, 1999; 27 SDR 54, effective December 4, 2000; 30 SDR 39, effective September 28, 2003; 31 SDR 21, effective August 23, 2004; 33 SDR 59, effective October 5, 2006; 34 SDR 271, effective May 6, 2008; 35 SDR 165, effective December 22, 2008; 36 SDR 209, effective July 1, 2010; 37 SDR 241, effective July 1, 2011; 38 SDR 219, effective June 25, 2012; 39 SDR

219, effective June 26, 2013; 41 SDR 41, effective September 17, 2014; 42 SDR 52, effective October 13, 2015; 42 SDR 177, effective June 28, 2016; 43 SDR 181, effective July 7, 2017; 45 SDR 10, effective August 2, 2018; 46 SDR 26, effective September 4, 2019.

General Authority: SDCL 58-27-108.

Law Implemented: SDCL 58-27-108.

Reference: Purposes and Procedures Manual of the Investment Analysis Office of the National Association of Insurance Commissioners, ~~2018~~ 2019 edition, National Association of Insurance Commissioners. Copies may be obtained from the NAIC, 1100 Walnut Street, Ste. 1500, Kansas City, MO 64106-2197, (816) 783-8300. Cost: ~~$50~~ $75.

20:06:36:01. Definitions. ~~Terms~~ As used in this chapter ~~mean~~:

(1) "Adjusted RBC report~~,~~" means an RBC report which has been adjusted by the director in accordance with § 20:06:36:06;

(2) "Corrective order~~,~~" means an order issued by the director specifying corrective actions which the director has determined are required;

(3) "Domestic insurer~~,~~" means any insurance company domiciled in this state or any entity required to comply with RBC pursuant to ~~§~~ SDCL 58-4-48;

(4) "Domestic health organization~~,~~" means any health organization domiciled in this state;

(5) "Foreign insurer~~,~~" means any insurance company which is licensed to do business in this state but is not domiciled in this state;

(6) "Foreign health organization~~,~~" means any health organization that is licensed to do business in this state, but is not domiciled in this state;

(7) "Health Organization~~,~~" means any health maintenance organization, limited health service organization, dental or vision plan, hospital, medical and dental indemnity or service corporation or other managed care organization licensed under SDCL ~~Title~~ title 58. This definition does not include an organization that is licensed as either a life or health insurer or property and casualty insurer, and that is otherwise subject to either life or property and casualty RBC requirements;

(8) "NAIC~~,~~" means the National Association of Insurance Commissioners;

(9) "Life or health insurer~~,~~" means any insurance company licensed under SDCL ~~Title~~ title 58 to write life or health, or a property and casualty insurer licensed to do business in this state writing only accident and health insurance;

(10) "Property and casualty insurer~~,~~" means any insurance company licensed under SDCL ~~Title~~ title 58 to do business in this state, but not monoline mortgage guaranty insurers, financial guaranty insurers, and title insurers;

(11) "Negative trend~~,~~" means for a life or health insurer, a negative trend in the level of risk-based capital over a period of time;

(12) "RBC~~,~~" means risk-based capital;

(13) "RBC instructions~~,~~" means the ~~2018~~ 2019 **NAIC RBC Forecasting and Instructions-Life**, the ~~2018~~ 2019 **NAIC RBC Forecasting and Instructions-Property/Casualty**, and the ~~2018~~ 2019 **NAIC RBC Forecasting and Instructions-Health**;

(14) "RBC plan~~,~~" means a comprehensive financial plan containing the elements specified in § 20:06:36:08. If the director rejects the RBC plan and it is revised by the insurer or health organization, with or without the director's recommendation, the plan is called the "revised RBC plan";

(15) "RBC report~~,~~" means the report required in §§ 20:06:36:03 ~~to~~ through 20:06:36:06~~, inclusive~~;

(16) "Total adjusted capital~~,~~" means the sum of an insurer's or health organization's statutory capital and surplus as determined in accordance with the statutory accounting applicable to the annual financial statements required to be filed under SDCL 58-6-75, and any other items required by the RBC instructions.

Source: 23 SDR 228, effective July 3, 1997; 25 SDR 13, effective August 9, 1998; 26 SDR 26, effective September 1, 1999; 27 SDR 54, effective December 4, 2000; 30 SDR 39, effective September 28, 2003; 31 SDR 21, effective August 23, 2004; 33 SDR 59, effective October 5, 2006; 34 SDR 271, effective May 6, 2008; 35 SDR 165, effective December 22, 2008; 36 SDR 209, effective July 1, 2010; 37 SDR 241, effective July 1, 2011; 38 SDR 219, effective June 25, 2012; 39 SDR 219, effective June 26, 2013; 41 SDR 41, effective September 17, 2014; 41 SDR 93, effective December 3, 2014; 42 SDR 52, effective October 13, 2015; 42 SDR 177, effective June 28, 2016; 43 SDR 181, effective July 7, 2017; 45 SDR 10, effective August 2, 2018; 46 SDR 26, effective September 4, 2019.

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48.

References:

1. **~~2018~~ 2019 NAIC RBC Forecasting and Instructions-Life.** Cost: ~~$45~~ $100.

2. **~~2018~~ 2019 NAIC RBC Forecasting and Instructions-Property/Casualty**. Cost: ~~$45~~ $100.

3. **~~2018~~ 2019 NAIC RBC Forecasting and Instructions-Health.** Cost: ~~$45~~ $100.

Copies of references 1 ~~and~~ through 3~~, inclusive,~~ may be obtained from the National Association of Insurance Commissioners, 1100 Walnut Street, Ste. 1500, Kansas City, MO 64106-2197, (816) 783-8300; http://www.naic.org.

20:06:59:01. Valuation manual -- operative date. The valuation of reserve liabilities for life insurance contracts, annuity and pure endowment contracts, accident and health contracts, and deposit-type contracts ~~shall~~ must be calculated in accordance with the standards set forth in the Valuation Manual of the National Association of Insurance Commissioners, ~~2018~~ 2020 edition. The operative date for the valuation manual is January 1, ~~2017~~ 2020.

Source: 43 SDR 80, effective December 5, 2016; 45 SDR 10, effective August 2, 2018; 46 SDR 26, effective September 4, 2019.

General Authority: SDCL 58-26-45.1.

Law Implemented: SDCL 58-26-44.1(11), 58-26-45.1.

Reference: Valuation Manual of the National Association of Insurance Commissioners, ~~2018~~ 2020 edition, National Association of Insurance Commissioners. Copies may be obtained from the NAIC, 1100 Walnut Street, Ste. 1500, Kansas City, MO 64106-2197, (816) 783-8300.

ARTICLE 20:06

INSURANCE

Chapter

20:06:05 Voting proxies of domestic mutuals, Repealed.

20:06:06 Credit life, health, and unemployment insurance.

20:06:07 Variable annuity contracts.

20:06:08 Life insurance and annuities.

20:06:09 Insurance holding companies.

20:06:10 Advertisements and solicitations of health and life insurance.

20:06:11 Restrictions on insiders' interests.

20:06:12 Examinations.

20:06:13 Medicare supplement insurance.

20:06:14 Health and life insurance solicitation, Repealed.

20:06:15 Countersignature fees -- Title insurance, Repealed.

20:06:16 Premium tax.

20:06:17 Generic naming of life insurance, Repealed.

20:06:18 Producer licensing.

20:06:19 Exchange-traded call and put options.

20:06:20 Interest rate futures.

20:06:21 Long-term care insurance.

20:06:22 Loss ratios for health insurance policies.

20:06:23 Financial condition of insurers.

20:06:24 Life reinsurance, Repealed.

20:06:25 Annual financial filing requirements.

20:06:26 Rating and valuation of investments.

20:06:27 Standardized health care forms.

20:06:28 Form filing requirements.

20:06:29 Cancellations and replacements.

20:06:30 Life and health reinsurance.

20:06:31 Credit for reinsurance.

20:06:32 Declaratory rulings.

20:06:33 Utilization review organizations and managed care entities.

20:06:34 Grievance procedures.

20:06:35 Maternity coverage.

20:06:36 Risk-based capital (RBC) reports.

20:06:37 Actuarial opinions and memorandums.

20:06:38 Life insurance illustrations.

20:06:39 Individual plans.

20:06:40 Employer plans.

20:06:41 HIPAA rules -- Small employer.

20:06:42 Associations eligible for group health insurance.

20:06:43 Annuity mortality tables.

20:06:44 Insurance fraud prevention unit.

20:06:45 Privacy of consumer financial and health information.

20:06:46 HIPAA rules -- Nondiscrimination in the group market.

20:06:47 Group disability benefits.

20:06:48 Health insurance risk pool.

20:06:49 Discount plans.

20:06:50 Coordination of benefits.

20:06:51 Mortality tables for use in determining minimum reserve liabilities.

20:06:52 Discretionary clauses.

20:06:53 External and internal review.

20:06:54 Preventive services.

20:06:55 Market regulations.

20:06:56 Minimum benefit standards.

20:06:57 Self-funded multiple employer trusts.

20:06:58 Mental Health Parity.

20:06:59 Principle-based reserving.

20:06:60 Insurer Corporate Governance.

CHAPTER 20:06:60

INSURER CORPORATE GOVERNANCE

Section

20:06:60:01. Definition of Senior Management. The term "senior management" means a corporate officer who either reports or has a duty to report information to the board of

directors, to shareholders, or to regulators. The term may include a chief executive officer, a chief financial officer, a chief operations officer, a chief procurement officer, a chief legal officer, a chief information officer, or any other "c" level executive.

Source:

General Authority: SDCL 58-5-166.

Law Implemented: SDCL 58-5-166.

20:06:60:02. Contents of Corporate Governance Annual Disclosure. An insurer or an insurance group shall, with the descriptive filing of its corporate governance annual disclosure, attach and label the documents that are used in its governance process. To the extent information is substantially similar to information in a document that was previously filed with the director, the insurer or insurance group shall, in lieu of submitting that document, attach a statement that identifies the specific location within the document and the date it was filed.

Source:

General Authority: SDCL 58-5-166.

Law Implemented: SDCL 58-5-163, 58-5-165, 58-5-166.

20:06:60:03. Annual Update. Each year following the initial filing of the corporate governance annual disclosure, the insurer or insurance group shall include with the submission of its corporate governance annual disclosure a statement that identifies any difference between the information reported in the disclosure filed for the current year and the disclosure filed for the prior year, or certify no difference exits.

Source:

General Authority: SDCL 58-5-166.

Law Implemented: 58-5-163, SDCL 58-5-166.

20:06:60:04. Description of Corporate Framework. The corporate governance annual disclosure must fully describe the insurer's or insurance group's corporate governance framework and structure, including:

(1) All individuals, the board, and any committees responsible for overseeing the insurer or insurance group and their legal relationship to the insurer or insurance group.

(2) The rationale for the current board size and structure;

(3) The duties of the board and each of its committees, and identification of the bylaws, charters, informal mandates, or other governance documents in which these duties are specified; and

(4) A description of how the leadership of the insurance group is structured, including a discussion of the roles of chief executive officer and chairman of the board.

Source:

General Authority: SDCL 58-5-166.

Law Implemented: SDCL 58-5-166.

20:06:60:05. Description of Policies and Practices. The corporate governance annual disclosure of an insurer or insurance group must describe the policies and practices of the insurer's or insurance group's board and committees, or, if governed by another entity, the board and committees of the insurer's or insurance group's most senior governing entity. The description must include:

(1) How the qualifications, expertise, and experience of each board member meet the needs of the insurer or insurance group;

(2) How an appropriate amount of independence is maintained on the board and its committees;

(3) The number of meetings held by the board and its committees over the reporting period as well as information on director attendance;

(4) How members of the board and its committees are identified, nominated, and elected, including:

(a) Whether a nomination committee is in place to identify and select individuals for consideration;

(b) Whether term limits are placed on directors;

(c) How the election and re-election processes function; and

(d) Whether a board diversity policy is in place and, if so, how it functions;

(5) The processes in place for the board to evaluate its performance and the performance of its committees; and

(6) Any recent measures taken by the board to improve performance, including any board or committee training programs that have been put in place.

Source:

General Authority: SDCL 58-5-166.

Law Implemented: SDCL 58-5-166.

20:06:60:06. Description of Senior Management. The insurer or insurance group shall describe the policies and practices for directing senior management in its corporate governance annual disclosure, including:

(1) Suitability standards and any other processes or practices that determine whether officers and key persons in control functions have the appropriate background, experience, and integrity to fulfill their prospective roles, such as:

(a) Identification of the specific positions for which suitability standards have been developed and a description of the standards employed; and

(b) Any changes in suitability standards and procedures to monitor and evaluate such changes regarding suitability for specific positions;

(2) The insurer's or insurance group's code of business conduct and ethics, which may include:

(a) Compliance with laws, rules, and regulations; and

(b) Proactive reporting of any illegal or unethical behavior;

(3) The insurer's or insurance group's processes for performance evaluation, compensation, and corrective action to ensure effective senior management throughout the organization, including a description of the general objectives of significant compensation programs and what the programs are designed to reward. The description must include sufficient detail to allow the director to understand how the organization ensures that compensation programs neither encourage nor reward excessive risk taking. Elements to be discussed may include:

(a) The board's role in overseeing management compensation programs and practices;

(b) The various elements of compensation awarded in the insurer's or insurance group's compensation programs and how the insurer or insurance group determines and calculates the amount of each element of compensation paid;

(c) How compensation programs are related to both company and individual performance over time;

(d) Whether compensation programs include risk adjustments and how those adjustments are incorporated into the programs for employees at different levels;

(e) Any claw back provisions built into the programs to recover awards or payments if the performance measures upon which they are based are restated or otherwise adjusted; and

(f) Any other factors relevant in understanding how the insurer or insurance group monitors its compensation policies to determine whether its risk management objectives are met by incentivizing its employees; and

(4) The insurer's or insurance group's plan for chief executive officer and senior management succession.

Source:

General Authority: SDCL 58-5-166.

Law Implemented: SDCL 58-5-166.

20:06:60:07. Description of Board Oversight. The insurer or insurance group shall describe the processes in its corporate governance annual disclosure by which the board, its committees, and senior management ensure an appropriate amount of oversight of the critical risk areas impacting the insurer's business activities, including:

(1) How oversight and management responsibilities are delegated between the board, its committees, and senior management;

(2) How the board is kept informed of the insurer's strategic plans, the associated risks, and steps that senior management is taking to monitor and manage those risks; and

(3) The process and frequency by which information on each critical risk area is reported to and reviewed by senior management and the board, which may include:

(a) Risk management processes, which may refer to an Own Risk and Solvency Assessment Summary Report if filed pursuant to SDCL chapter 58-5A;

(b) Actuarial function;

(c) Investment decision-making processes;

(d) Reinsurance decision-making processes;

(e) Business strategy or finance decision-making processes;

(f) Compliance function;

(g) Financial reporting or internal auditing; and

(h) Market conduct decision-making processes.

Source:

General Authority: SDCL 58-5-166.

Law Implemented: SDCL 58-5-166.