20:06:12:07. Guidelines for examination reports. The insurer's examination report shall be prepared in accordance with standards adopted by the National Association of Insurance Commissioners in the **Financial Condition Examiners Handbook**, ~~2013~~ 2014 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.

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

Law Implemented: SDCL 58-3-3.3, 58-3-11.

Reference: Financial Condition Examiners Handbook, ~~2013~~ 2014 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.

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.

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 Part A Deductible	Basic, including 100% Part B coinsurance Skilled Nursing Facility Coinsurance	Basic, including 100% Part B coinsurance Skilled Nursing Facility Coinsurance	Basic, including 100% Part B coinsurance* Skilled Nursing Facility Coinsurance		Basic, including 100% Part B coinsurance Skilled Nursing Facility Coinsurance

Part A Deductible Part B Deductible Foreign Travel Emergency	Part A Deductible Foreign Travel Emergency	Part A Deductible Part B Deductible Excess (100%) Foreign Travel Emergency	Part A Deductible Part B Excess (100%) 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	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit $[~~4660~~ 4800]; paid at 100% after limit reached	Out-of-pocket limit $[~~2330~~ 2400]; 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 $~~2070~~ 2140 deductible. Benefits from high

deductible Plan F will not begin until out-of-pocket expenses exceed $~~2070~~ 2140. 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.]

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 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.]

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 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 $[~~1156~~ 1216] All but $[~~289~~ 304] a day All but $[~~556~~ 608] a day $0 $0	$0 $[~~289~~ 304] a day $[~~556~~ 608] a day 100% of Medicare eligible expenses $0	$[~~1156~~ 1216] (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	All approved amounts All but $[~~144.50~~ 152] a day $0	$0 $0 $0	$0 Up to $[~~144.50~~ 152] a day All costs

101st day and after			
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 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 $[~~140~~ 147] 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 $[~~140~~ 147] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 Generally 80%	$0 Generally 20%	$[~~140~~ 147] (Part B deductible) $0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints Next $[~~140~~147] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 $0 80%	All costs $0 20%	$0 $[~~140~~ 147] (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	100%	$0	$0
MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies	$0 80%	$0 20%	$[~~140~~ 147] (Part B deductible) $0
---Durable medical equipment			
First $[~~140~~ 147] of Medicare approved amounts*			
Remainder of Medicare approved amounts			

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 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 $[~~1156~~ 1216] All but $[~~289~~ 304] a day All but $[~~578~~ 608] a day $0 $0	 $[~~1156~~ 1216](Part A deductible) $[~~289~~ 304] a day $[~~578~~ 608] 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	 All approved amounts All but $[~~144.50~~ 152] a day $0	 $0 $0 $0	$0 Up to $[~~144.50~~ 152] a day All costs

101st day and after			
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 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 $[~~140~~147] 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 $[~~140~~ 147] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 Generally 80%	$0 Generally 20%	$[~~140~~ 147] (Part B deductible) $0
Part B Excess Charges (Above Medicare Approved Amounts	$0	$0	All costs
BLOOD First 3 pints Next $[~~140~~ 147] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 $0 80%	All costs $0 20%	$0 $[~~140~~ 147] (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 $[~~140~~ 147] of Medicare approved amounts* Remainder of Medicare approved amounts	100% $0 80%	$0 $0 20%	$0 $[~~140~~ 147] (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 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 $[~~1156~~ 1216] All but $[~~289~~ 304] a day All but $[~~578~~ 608] a day $0 $0	 $[~~1156~~ 1216](Part A deductible) $[~~289~~ 304] a day $[~~578~~ 608] 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	 All approved amounts All but $[~~144.50~~ 152] a day $0	 $0 Up to $ [~~144.50~~ 152] a day $0	$0 $0 All costs

101st day and after			
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 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 $[~~140~~ 147] 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 $[~~140~~ 147] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 Generally 80%	$[~~140~~ 147] (Part B deductible) Generally 20%	$0 $0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints Next $[~~140~~ 147] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 $0 80%	All costs $[~~140~~ 147] (Part B deductible) 20%	$0 $0 $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 $[~~140~~ 147] of Medicare approved amounts* Remainder of Medicare approved amounts	100% $0 80%	$0 $[~~140~~ 147] (Part B deductible) 20%	$0 $0 $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 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 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 $[~~1156~~ 1216] All but $[~~289~~ 304] a day All but $[~~578~~ 608] a day $0 $0	$[~~1156~~ 1216](Part A deductible) $[~~289~~ 304] a day $[~~578~~ 608] 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	All approved amounts All but $[~~144.50~~ 152] a day $0	$0 Up to $ [~~144.50~~ 152] a day $0	$0 $0 All costs

101st day and after			
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 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 $[~~140~~ 147] 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 $[~~140~~ 147] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 Generally 80%	$0 Generally 20%	$[~~140~~ 147] (Part B deductible) $0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints Next $[~~140~~ 147] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 $0 80%	All costs $0 20%	$0 $[~~140~~ 147] (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 $[~~140~~ 147] of Medicare approved amounts* Remainder of Medicare approved amounts	100% $0 80%	$0 $0 20%	$0 $[~~140~~ 147] (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 one has paid a calendar year $[~~2070~~ 2140] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $[~~2070~~ 2140]. 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 $[~~2070~~ 2140] DEDUCTIBLE,** PLAN PAYS]	[IN ADDITION TO $[~~2070~~ 2140] DEDUCTIBLE,** YOU PAY]
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: --Additional 365 days --Beyond the additional 365 days	All but $[~~1156~~ 1216] All but $[~~289~~ 304] a day All but $[~~578~~ 608] a day $0 $0	$[~~1156~~ 1216](Part A deductible) $[~~289~~ 304] a day $[~~578~~ 608] a day 100% of Medicare eligible expenses $0	$0 $0 $0 $0*** All costs
SKILLED NURSING			$0

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 $[~~144.50~~ 152] a day $0	$0 Up to $[~~144.50~~ 152] a day $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 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 $[~~140~~ 147] 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 $[~~2070~~ 2140] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $[~~2070~~ 2140]. 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 $[~~2070~~ 2140] DEDUCTIBLE,** PLAN PAYS]	[IN ADDITION TO $[~~2070~~ 2140] 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 $[~~140~~ 147] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 Generally 80%	$[~~140~~ 147] (Part B deductible) Generally 20%	$0 $0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints	$0 $0	All costs $[~~140~~ 147] (Part B deductible)	$0 $0

Next $[~~140~~ 147] of Medicare approved amounts* 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 $[~~2070~~ 2140] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[~~2070~~ 2140] DEDUCTIBLE,**] YOU PAY'
HOME HEALTH CARE MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies ---Durable medical equipment ---First $[~~140~~ 147] of Medicare approved amounts* Remainder of Medicare approved amounts	100% $0 80%	$0 $[~~140~~ 147] (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 $[~~2070~~ 2140] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[~~2070~~ 2140] 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 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 G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 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 $[~~1156~~ 1216] All but $[~~289~~ 304] a day All but $[~~578~~ 608] a day $0 $0	 $[~~1156~~ 1216](Part A deductible) $[~~289~~ 304] a day $[~~578~~ 608] 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	 All approved amounts All but $[~~144.50~~ 152] a day $0	 $0 Up to $[~~144.50~~ 152] a day $0	$0 $0 All costs

101th day and after			
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 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

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

*Once you have been billed $[~~140~~ 147] 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 $[~~140~~ 147] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 Generally 80%	$0 Generally 20%	$[~~140~~ 147] (Part B deductible) $0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	0%
BLOOD First 3 pints Next $[~~140~~ 147] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 $0 80%	All costs $0 20%	$0 $[~~140~~ 147] (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			$0
MEDICARE APPROVED SERVICES	100%	$0	$[~~140~~ 147] (Part B deductible)
---Medically necessary skilled care services and medical supplies	$0	$0	$0
---Durable medical equipment	80%	20%	
First $[~~140~~ 147] of Medicare approved amounts*			
Remainder of Medicare approved amounts			

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

PLAN K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[~~4660~~ 4940] 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 $[~~1156~~ 1216]	$[~~578~~ 608] (50% of Part A deductible)	$[~~578~~ 608] (50% of Part A deductible)♦
61st thru 90th day	All but $[~~289~~ 304] a day	$[~~289~~ 304] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[~~578~~ 608] a day	$[~~578~~ 608] a day	$0
--Once lifetime reserve days are used:			
--Additional 365 days		100% of Medicare eligible expenses	$0***
--Beyond the additional 365 days	$0	$0	All costs
	$0		
SKILLED NURSING FACILITY CARE**	All approved amounts	$0	$0
You must meet	All but $[~~144.50~~ 152] a	Up to $[~~72.75~~ 76] a day (50% of Part A	Up to $[~~72.75~~ 76] a day (50% of Part A

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	day $0	coinsurance) $0	coinsurance)♦ All costs
BLOOD First 3 pints Additional amounts	$0 100%	50% $0	50%♦ $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 $[~~140~~ 147] 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 $[~~140~~ 147] 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%	$[~~140~~ 147] (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 $[~~4660~~ 4940])*
BLOOD First 3 pints Next $[~~140~~ 147] of Medicare approved amounts**** Remainder of Medicare approved amounts	$0 $0 Generally 80%	50% $0 Generally 10%	$50%♦ $[~~140~~ 147] (Part B deductible)****♦ Generally 10%♦
CLINICAL LABORATORY	100%	$0	$0

SERVICES --TESTS FOR DIAGNOSTIC SERVICES			

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[~~4660~~ 4940] 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	100%	$0	$0
MEDICARE APPROVED SERVICES	$0	$0	$[~~140~~ 147] (Part B deductible)♦
--Medically necessary skilled care services and medical supplies	80%	10%	10%♦
--Durable medical equipment			
First $[~~140~~ 147] of Medicare approved amounts *****			
Remainder of Medicare approved amounts			

*****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 $[~~2330~~ 2470] 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 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 $[~~1156~~ 1216] All but $[~~289~~ 304] a day All but $[~~578~~ 608] a day $0 $0	$[~~849~~ 912] (75% of Part A deductible) $[~~289~~ 304] a day $[~~578~~ 608] a day 100% of Medicare eligible expenses $0	$[~~289~~ 304] (25% of Part A deductible)♦ $0 $0 $0*** All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in	All approved amounts All but $[~~144.50~~ 152] a day $0	$0 Up to $[~~108.38~~ 114] a day (75% of Part A Coinsurance)	$0 Up to $[~~36.13~~ 38] a day (25% of Part A Coinsurance)♦

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		$0	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 ♦

***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 $[~~140~~ 147] 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 $[~~140~~ 147] 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%	$[~~140~~ 147] (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 $[~~2330~~ 2470])*
BLOOD First 3 pints Next $[~~140~~ 147] of Medicare approved amounts**** Remainder of Medicare approved amounts	$0 $0 Generally 80%	75% $0 Generally 15%	$25% $[~~140~~ 147] (Part B deductible)****♦ Generally 5%♦
CLINICAL LABORATORY	100%	$0	$0

SERVICES --TESTS FOR DIAGNOSTIC SERVICES			

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[~~2330~~ 2470] 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	100%	$0	$0
MEDICARE APPROVED SERVICES	$0	$0	$[~~140~~ 147] (Part B deductible)♦
--Medically necessary skilled care services and medical supplies	80%	15%	5%♦
--Durable medical equipment			
First $[~~140~~ 147] of Medicare approved amounts *****			
Remainder of Medicare approved amounts			

*****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 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 $[~~1156~~ 1216] All but $[~~289~~ 304] a day All but $[~~578~~ 608] a day $0 $0	$[~~578~~ 608] (50% of Part A deductible) $[~~289~~ 304] a day $[~~578~~ 608] a day 100% of Medicare eligible expenses $0	$[~~578~~ 608] (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	All approved amounts All but $[~~144.50~~ 152] a day $0	$0 Up to $[~~144.50~~ 152] a day $0	$0 $0 All costs

21st thru 100th day 101st day and after			
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

**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 $[~~140~~ 147] 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 $[~~140~~ 147] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 Generally 80%	$0 Generally 20%	$[~~140~~ 147] (Part B deductible) $0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints Next $[~~140~~ 147] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 $0 80%	All costs $0 20%	$0% $[~~140~~ 147] (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	100%	$0	$0
MEDICARE APPROVED SERVICES	$0	$0	$[~~140~~ 147] (Part B deductible)
--Medically necessary skilled care services and medical supplies	80%	20%	$0
--Durable medical equipment			
First $[~~140~~ 147] of Medicare approved amounts *			
Remainder of Medicare approved amounts			

OTHER BENEFITS -- NOT COVERED BY MEDICARE

FOREIGN TRAVEL	$0	$0	$250
NOT COVERED BY MEDICARE	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
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			

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 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 $[~~1156~~ 1216] All but $[~~289~~ 304] a day All but $[~~578~~ 608] a day $0 $0	$[~~1156~~ 1216] (Part A deductible) $[~~289~~ 304] a day $[~~578~~ 608] 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	All approved amounts All but $[~~144.50~~ 152] a day $0	$0 Up to $[~~144.50~~ 152] a day $0	$0 $0 All costs

21st thru 100th day 101st day and after			
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

**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 $[~~140~~ 147] 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 $[~~140~~ 147] 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	$[~~140~~ 147] (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 $[~~140~~ 147] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 $0 80%	All costs $0 20%	$0% $[~~140~~ 147] (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	100%	$0	$0
MEDICARE APPROVED SERVICES	$0	$0	$[~~140~~ 147] (Part B deductible)
--Medically necessary skilled care services and medical supplies	80%	20%	$0
--Durable medical equipment			
First $[~~140~~ 147] of Medicare approved amounts*			
Remainder of Medicare approved amounts			

OTHER BENEFITS -- NOT COVERED BY MEDICARE

FOREIGN TRAVEL	$0	$0	$250
NOT COVERED BY MEDICARE	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
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			

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 ~~2012~~ 2013 edition of the **Annual Statement Instructions**, the ~~2013~~ 2014 edition **Financial Condition Examiners Handbook**, the ~~2013~~ 2014 edition **Accounting Practices and Procedures Manual**, and the ~~2012~~ 2013 edition **Purposes and Procedures Manual of the NAIC Securities Valuation 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.

General Authority: SDCL 58-27-7.

Law Implemented: SDCL 58-27-7.

References:

1. **Annual Statement Instructions - Life, Accident and Health**, ~~2012~~ 2013 edition, National Association of Insurance Commissioners. Cost: $200.

2. **Annual Statement Instructions - Property and Casualty**, ~~2012~~ 2013 edition, National Association of Insurance Commissioners. Cost: $200.

3. **Accounting Practices and Procedures Manual**, Volumes I, II, and III March ~~2013~~ 2014, National Association of Insurance Commissioners. Cost: Hard Copy, $465; CD ROM $395.

4. **Financial Condition Examiners Handbook**, ~~2013~~ 2014 edition, National Association of Insurance Commissioners. Cost: $250.

5. **Purposes and Procedures Manual of the NAIC Securities Valuation Office (SVO)**, December ~~2012~~ 2013 edition, National Association of Insurance Commissioners. Cost: $50.

Copies of references 1 to 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 be filed in accordance with the standards adopted by the National Association of Insurance Commissioners in the ~~2013~~ 2014 editions of the **Accounting Practices and Procedures Manual** and the ~~2012~~ 2013 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.

General Authority: SDCL 58-6-75.

Law Implemented: SDCL 58-6-75.

References:

1. **Annual Statement Instructions - Life, Accident, and Health**, ~~2012~~ 2013 edition. Cost: $200.

2. **Annual Statement Instructions - Property and Casualty**, ~~2012~~ 2013 edition. Cost: $200.

3. **Annual Statement Instructions - Health**, ~~2012~~ 2013 edition. Cost: $200.

4. **Annual Statement Instructions - Title**, ~~2012~~ 2013 edition. Cost: $200.

5. **Accounting Practices and Procedures Manual**, ~~2013~~ 2014. Cost: Hard Copy, $465; CD ROM, $395.

Copies of references 1 to 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.

General Authority: SDCL 58-6-75.

Law Implemented: SDCL 58-6-75.

Reference: Accounting Practices and Procedures Manual, Volumes I, II, and III ~~2013~~ 2014. 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.

General Authority: SDCL 58-6-75.

Law Implemented: SDCL 58-6-75.

Reference: Accounting Practices and Procedures Manual, Volumes I, II, and III ~~2013~~ 2014. 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**, ~~2012~~ 2013 edition and **Annual Statement Instructions - Property and Casualty**, ~~2012~~ 2013 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.

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**, ~~2012~~ 2013 edition. Cost: $200.

2. **Annual Statement Instructions - Property and Casualty**, ~~2012~~ 2013 edition. Cost: $200.

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 Securities Valuation Office of the National Association of Insurance Commissioners**, December ~~2012~~ 2013 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.

General Authority: SDCL 58-27-108.

Law Implemented: SDCL 58-27-108.

Reference: Purposes and Procedures Manual of the Securities Valuation Office of the National Association of Insurance Commissioners, ~~2012~~ 2013 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.

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

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

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

(3) "Domestic insurer," any insurance company domiciled in this state;

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

(5) "NAIC," the National Association of Insurance Commissioners;

(6) "Life or health insurer," any insurance company licensed to do business in this state, or a property and casualty insurer licensed to do business in this state writing only accident and health insurance;

(7) "Property and casualty insurer," any insurance company licensed to do business in this state, but not monoline mortgage guaranty insurers, financial guaranty insurers, and title insurers;

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

(9) "RBC," risk-based capital;

(10) "RBC instructions," the ~~2012~~ 2013 **NAIC Life Risk-Based Capital Report**, the ~~2012~~ 2013 **NAIC Property and Casualty Risk-Based Capital Report**, and the ~~2012~~ 2013 **NAIC Health Risk-Based Capital Report**;

(11) "RBC plan," 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, with or without the director's recommendation, the plan is called the "revised RBC plan";

(12) "RBC report," the report required in §§ 20:06:36:03 to 20:06:36:06, inclusive;

(13) "Total adjusted capital," the sum of an insurer'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.

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48.

References:

1. ~~**2012**~~ **2013 NAIC Life Risk-Based Capital Report.** Cost: $45.
2. ~~**2012**~~ **2013 NAIC Property and Casualty Risk-Based Capital Report.** Cost: $45.
3. ~~**2012**~~ **2013 NAIC Health Risk-Based Capital Report.** Cost: $45.

Copies of references 1 to 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.

20:06:36:04. Life and health insurer's RBC reports. A life and health insurer's RBC report shall be determined in accordance with the formula set forth in the RBC instructions in the ~~2012~~ 2013 **NAIC Life Risk-Based Capital Report** and the ~~2012~~ 2013 **NAIC Health Risk-Based Capital Report.** The formula shall take into account, and may adjust for the covariance

between, the following factors determined in each case by applying the factors in the manner set forth in the RBC instructions:

(1) The risk to the insurer's assets;

(2) The risk of adverse insurance experience to the insurer's liabilities and obligations;

(3) The interest rate risk to the insurer's business; and

(4) All other business risks and any other relevant risks as set forth in 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.

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48.

References:

1. ~~**2012**~~ **2013 NAIC Life Risk-Based Capital Report.** Cost: $45.

2. ~~**2012**~~ **2013 NAIC Health Risk-Based Capital Report.** Cost: $45.

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.

20:06:36:05. Property and casualty insurer's RBC reports. A property and casualty insurer's RBC report shall be determined in accordance with the formula set forth in the RBC

instructions in the ~~2012~~ 2013 **NAIC Property and Casualty Risk-Based Capital Report**. The formula shall take into account, and may adjust for the covariance between, the following factors determined in each case by applying the factors in the manner set forth in the RBC instructions:

(1) Asset risk;

(2) Credit risk;

(3) Underwriting risk; and

(4) All other business risks and any other relevant risks as set forth in 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.

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48.

Reference: ~~2012~~ 2013 NAIC Property and Casualty Risk-Based Capital Report; 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; http://www.naic.org. Cost: $45.

20:06:42:01. Eligible associations defined. An association is a group of persons who have joined for some common purpose or goal. An association is eligible for the issuance of group health insurance if all of the following factors are met and filed for approval by the director:

(1) There is a shared or common purpose that is not generally applicable to the population at large;

(2) There is a constitution and by-laws which indicate a legitimate purpose other than the purchase of insurance; and

(3) The primary method of obtaining new members is not through, or in conjunction with, the solicitation of insurance. However, solicitation of insurance may be one of the methods of obtaining new members.

When determining eligibility for the issuance of group health insurance, the division may consider whether the association ever existed independently of an insurance product.

Source: 26 SDR 44, effective October 6, 1999.

General Authority: SDCL 58-18-62.

Law Implemented: SDCL 58-18-3, 58-18-6.