20:06:01:01. Definitions. Terms used in this article mean:

(1) "Director," the director of the Division of Insurance, Department of ~~Commerce~~ Labor and Regulation;

(2) "Division," the Division of Insurance, Department of ~~Commerce~~ Labor and Regulation;

(3) "Department," the Department of ~~Commerce~~ Labor and Regulation.

Source: 15 SDR 143, effective March 29, 1989.

General Authority: SDCL 58-4-1.

Law Implemented: SDCL 58-33-5, 58-33-6, 58-33-7, 58-33-8.

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**, ~~2014~~ 2015 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.

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

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

Reference: Financial Condition Examiners Handbook, ~~2014~~ 2015 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.

20:06:13:21.01. Refund or credit calculation. An issuer shall collect and file with the director by May 31 of each year the data required on the forms in Appendix A at the end of this chapter for each type in a standard Medicare supplement benefit plan.

If, on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), a refund or credit calculation is required. The refund or credit calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued with the reporting year shall be excluded.

For purposes of this section, for policies or certificates issued before July 17, 1992, the issuer shall make the refund or credit calculation separately for all individual policies combined, including all group policies subject to an individual loss ratio standard when issued, and all other group policies combined for experience after the effective date of this amendment. The first such report affected by this paragraph is due May 31, 1998.

The issuer may refund or credit only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds the sum of $5. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary of health and human services, but it may not be less than the average rate of interest for 13-week treasury notes on the date of refund or credit calculation as established by the federal reserve board and published in the Wall Street Journal. The issuer shall

make a refund or credit against premiums due by September 30 following the experience year upon which the refund or credit is based.

Source: 18 SDR 225, effective July 17, 1992; 22 SDR 107, effective February 18, 1996.

General Authority: SDCL 58-4-1, 58-17A-2.

Law Implemented: SDCL 58-17A-2, 58-17A-5.

Cross-Reference: Combination of experience for calculation of refund or credit, § 20:06:13:22.06.

Notes: As of the effective date of this rule, the secretary of the U.S. Department of Health and Human Services had not specified an interest rate.

Forms may be obtained from the South Dakota Division of Insurance, ~~445 East Capitol Avenue~~ 124 South Euclid Avenue, 2nd Floor, Pierre, SD 57501, (605) 773-3563, free of charge.

20:06:13:35. Notice of replacement. Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the agent, unless the coverage is sold without an agent, must be provided to the applicant and an additional signed copy must be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

The notice required by this section is in Appendix C at the end of this chapter. Notice used by an issuer must be in substantially the same form and in no less than twelve-point type. For purposes of this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

Unless the coverage is direct marketed, the agent must ask and record the answers to all questions on the forms.

Source: 8 SDR 174, effective July 1, 1982; 12 SDR 151, 12 SDR 155, effective July 1, 1986; 15 SDR 143, effective March 29, 1989; 18 SDR 225, effective July 17, 1992; 23 SDR 236, effective July 13, 1997; 37 SDR 215, effective May 31, 2011.

General Authority: SDCL 58-17A-2.

Law Implemented: SDCL 58-17A-2.

Note: A copy of the notice that meets the requirements of this section may be obtained by writing or calling the Division of Insurance, ~~445 E. Capitol Avenue~~ 124 South Euclid Avenue, 2nd Floor, Pierre, SD 57501 (605-773-3563) or writing NAIC, P.O. Box 38, Kansas City, MO 64183-0108.

20:06:13:51. Notice of benefit change. At least 30 days before the annual effective date of Medicare benefit changes each issuer, health care service plan, or other entity providing Medicare supplement insurance or benefits to a resident of this state shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the director or adopted by the NAIC. The notice must contain the following information:

(1) A description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement insurance policy or certificate;

(2) Information for each covered person about when any premium adjustment due to changes in Medicare benefits will be made; and

(3) Benefit modifications and any premium adjustments in outline form stated in clear and simple terms.

The notice may not contain or be accompanied by a solicitation.

Source: 15 SDR 143, effective March 29, 1989; 16 SDR 174, effective May 2, 1990; 18 SDR 225, effective July 17, 1992; 27 SDR 53, effective December 4, 2000.

General Authority: SDCL 58-4-1, 58-17A-2.

Law Implemented: SDCL 58-17A-2.

Cross-Reference: Policy forms -- Filing with and approved by the director, SDCL 58-11-12.

Note: A copy of a notice that meets the requirements of this section may be obtained from the Division of Insurance, ~~445 East Capitol Avenue~~ 124 South Euclid Avenue, 2nd Floor, Pierre, SD 57501 (605-773-3563), free of charge.

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.

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
	Part A Deductible	Skilled Nursing Facility Coinsurance Part A Deductible Part B Deductible Foreign Travel Emergency	Skilled Nursing Facility Coinsurance Part A Deductible Foreign Travel Emergency	Skilled Nursing Facility Coinsurance Part A Deductible Part B Deductible Excess (100%) Foreign Travel Emergency		Skilled Nursing Facility Coinsurance 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 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 $[~~4800~~4940]; paid at 100% after limit reached	Out-of-pocket limit $[~~2400~~2470]; 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 $~~2140~~ 2180 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $~~2140~~ 2180. 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	All but $[~~1216~~1260]	$0	$[~~1216~~1260] (Part A deductible)
61st thru 90th day	All but $[~~304~~315] a day	$[~~304~~315] a day	$0
91st day and after:			
--While using 60 lifetime reserve days		$[~~608~~630] a day	$0
--Once lifetime reserve days are used:	All but $[~~608~~630] a day		
--Additional 365 days		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 $[~~152~~157.50] a day	$0	Up to $[~~152~~157.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
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 $[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 $[147] of Medicare approved amounts*	$0	$0	$[147] (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 $[147] of Medicare approved amounts*	$0	$0	$[147] (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 $[147] of Medicare approved amounts*	$0	$0	$[147] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[~~1216~~1260]	$[~~1216~~1260](Part A deductible)	$0
61st thru 90th day	All but $[~~304~~315] a day	$[~~304~~315] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[~~608~~630] a day	$[~~630~~] 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 $[~~152~~157.50] a day	$0	Up to $[~~152~~157.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE 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 $[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 $[147] of Medicare approved amounts*	$0	$0	$[147] (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 $[147] of Medicare approved amounts*	$0	$0	$[147] (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 $[147] of Medicare approved amounts*	$0	$0	$[147] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0

PLAN C

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

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 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 $[~~1216~~1260]	$[~~1216~~1260](Part A deductible)	$0
61st thru 90th day	All but $[~~304~~315] a day	$[~~304~~315] day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[~~608~~630] a day	$[~~608~~630] 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 $[~~152~~157.50] a day	Up to $[~~152~~157.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE 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 $[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 $[147] of Medicare approved amounts*	$0	$[147] (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 $[147] of Medicare approved amounts*	$0	$[147] (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 $[147] of Medicare approved amounts*	$0	$[147] (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$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	$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 $[~~1216~~1260]	$[~~1216~~1260]Part A deductible)	$0
61st thru 90th day	All but $[~~304~~315] a day		$0
91st day and after:		$[~~304~~315a day	
--While using 60 lifetime reserve days	All but $[~~608~~630a day		$0
--Once lifetime reserve days are used:		$[~~608~~630a day	
--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 $[$[~~152~~157.50] a day	Up to $ [$[~~152~~157.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE 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 $[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 $[147] of Medicare approved amounts*	$0	$0	$[147] (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 $[147] of Medicare approved amounts*	$0	$0	$[147] (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 $[147] of Medicare approved amounts*	$0	$0	$[147] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$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	$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 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 $[~~2140~~2180] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $[~~2140~~2180]. 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 $[~~2140~~2180] DEDUCTIBLE,** PLAN PAYS]	[IN ADDITION TO $[~~2140~~2180] DEDUCTIBLE,** YOU PAY]
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[~~1216~~1260]	$[~~1216~~1260](Part A	$0
61st thru 90th day	All but $[~~304~~315] a day	deductible) $[~~304~~315] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[~~608~~630] a day		$0
--Once lifetime reserve days are used:		$[~~608~~630] a day	
--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 $[~~152~~157.50] a day	Up to $[~~152~~157.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE 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 $[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 $[~~2140~~2180] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $[~~2140~~2180]. 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 $[~~2140~~2180] DEDUCTIBLE,** PLAN PAYS]	[IN ADDITION TO $[~~2140~~2180] 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 $[147] of Medicare approved amounts*	$0	$[147] (Part B deductible)	$0
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[147] of Medicare approved amounts*	$0	$[147] (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	[AFTER YOU PAY $[~~2140~~2180] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[~~2140~~2180] DEDUCTIBLE,**] YOU PAY'
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	$0	$0
---Durable medical equipment			
---First $[147] of Medicare approved amounts*	$0	$[147] (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0

(continued)

PLAN F or HIGH DEDUCTIBLE PLAN F (continued)

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[~~2140~~2180] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[~~2140~~2180] 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

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 $[~~1216~~1260]	$[~~1216~~1260](Part A	$0
61st thru 90th day	All but $[~~304~~315] a day	deductible) $[~~304~~315] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[~~608~~630] a day		$0
--Once lifetime reserve days are used:		$[~~608~~630] a day	
--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 $[~~152~~157.50] a day	Up to $[~~152~~157.50] 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

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

*Once you have been billed $[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 $[147] of Medicare approved amounts*	$0	$0	$[147] (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	0%
BLOOD			
First 3 pints	$0	All costs	$0
Next $[147] of Medicare approved amounts*	$0	$0	$[147] (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 $[147] of Medicare approved amounts*	$0	$0	$[147] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$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	$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 $[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 $[~~1216~~1260]	$[~~608~~630] (50% of Part A deductible)	$[~~608~~630] (50% of Part A deductible)♦
61st thru 90th day	All but $[~~304~~315] a day	$[~~304~~315] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[~~608~~630] a day	$[~~608~~630] 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 $[~~152~~157.50] a day	Up to $[~~76~~78.75] a day (50% of Part A coinsurance)	Up to $[$[~~76~~78.75] 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 $[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 $[147] of Medicare approved amounts****	$0	$0	$[147] (Part B deductible)****♦
Preventative Benefits for Medicare covered services	Generally 80% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare approved amounts	Generally 80%	Generally 10%	Generally 10%
Part B Excess Charges (Above Medicare Approved Amounts)	$0	0%	All costs (and they do not count toward annual out-of-pocket limit of $[4940])*
BLOOD			
First 3 pints	$0	50%	$50%♦
Next $[147] of Medicare approved amounts****	$0	$0	$[147] (Part B deductible)****♦
Remainder of Medicare approved amounts	Generally 80%	Generally 10%	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 $[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 MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment			
First $[147] of Medicare approved amounts *****	$0	$0	$[147] (Part B deductible)♦
Remainder of Medicare approved amounts	80%	10%	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 $[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	All but $[~~1216~~1260]	$[~~912~~945] (75% of Part A deductible)	$[~~304~~315] (25% of Part A deductible)♦
61st thru 90th day	All but $[~~304~~315] a day	$[~~304~~315] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[~~608~~630] a day	$[~~608~~630] 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 $[~~152~~157.50] a day	Up to $[~~114~~118.13] a day (75% of Part A Coinsurance)	Up to $[~~38~~39.38] 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 $[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 $[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%	$[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 $[2470])*
BLOOD First 3 pints Next $[147] of Medicare approved amounts**** Remainder of Medicare approved amounts	$0 $0 Generally 80%	75% $0 Generally 15%	$25% $[147] (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 $[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 MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies --Durable medical equipment First $[147] of Medicare approved amounts ***** Remainder of Medicare approved amounts	100% $0 80%	$0 $0 15%	$0 $[147] (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 $[~~1216~~1260]	$[608] (50% of Part A deductible)	$[~~608~~630] (50% of Part A deductible)
61st thru 90th day	All but $[~~304~~315] a day	$[~~304~~315] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[~~608~~630] a day	$[~~608~~630] 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 $[~~152~~157.50] a day	Up to $[~~152~~157.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pint**s**	$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 $[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 $[147] of Medicare approved amounts*	$0	$0	$[147] (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 $[147] of Medicare approved amounts*	$0	$0	$[147] (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 $[147] of Medicare approved amounts *	$0	$0	$[147] (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 $[~~1216~~1260]	$[~~1216~~1260] (Part A	$0
61st thru 90th day	All but $[~~304~~315] a day	deductible)	$0
91st day and after:		$[~~304~~315] a day	
--While using 60 lifetime reserve days	All but $[~~608~~630] a day	$[~~608~~630] 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 $[~~152~~157.50] a day	Up to $[~~152~~157.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE 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 $[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 $[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	$[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 $[147] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 $0 80%	All costs $0 20%	$0% $[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 $[147] of Medicare approved amounts* Remainder of Medicare approved amounts	100% $0 80%	$0 $0 20%	$0 $[147] (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 Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum

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 ~~2013~~ 2014 edition of the **Annual Statement Instructions**, the ~~2014~~ 2015 edition **Financial Condition Examiners Handbook**, the ~~2014~~ 2015 edition **Accounting Practices and Procedures Manual**, and the ~~2013~~ 2014 edition **Purposes and Procedures Manual of the NAIC ~~Securities Valuation Office~~ 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.

General Authority: SDCL 58-27-7.

Law Implemented: SDCL 58-27-7.

References:

1. **Annual Statement Instructions - Life, Accident and Health**, ~~2013~~ 2014 edition, National Association of Insurance Commissioners. Cost: $200.

2. **Annual Statement Instructions - Property and Casualty**, ~~2013~~ 2014 edition, National Association of Insurance Commissioners. Cost: $200.

3. **Accounting Practices and Procedures Manual**, Volumes I, II, and III March ~~2014~~ 2015, National Association of Insurance Commissioners. Cost: Hard Copy, $465; CD ROM $395.

4. **Financial Condition Examiners Handbook**, ~~2014~~ 2015 edition, National Association of Insurance Commissioners. Cost: $250.

5. **Purposes and Procedures Manual of the NAIC ~~Securities Valuation Office (SVO)~~ Investment Analysis Office**, December ~~2013~~ 2014 edition, National Association of Insurance Commissioners. Cost: ~~$50~~ 100.

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.

20:06:21:54. Requirement to deliver shopper's guide. A long-term care insurance shopper's guide in the format as published by the National Association of Insurance Commissioners or a similar guide developed or approved by the director, must be provided to all prospective applicants of a long-term care insurance policy or certificate.

If the policy is solicited by an agent, the agent must deliver the shopper's guide before presenting an application or enrollment form to the prospective applicant. The shopper's guide must be presented in conjunction with any application or enrollment form if the policy is a direct response solicitation. Life insurance policies or riders containing accelerated long-term care

benefits are not required to furnish the shopper's guide, but must furnish the policy summary required by § 20:06:21:47.

Source: 23 SDR 55, effective October 20, 1996; 25 SDR 13, effective August 9, 1998; 31 SDR 214, effective July 6, 2005.

General Authority: SDCL 58-17B-4.

Law Implemented: SDCL 58-17B-4, 58-17B-10.

Reference: "A Shopper's Guide to Long-Term Care Insurance," revised 2005, National Association of Insurance Commissioners. Free copies may be obtained from the South Dakota Division of Insurance, ~~445 East Capitol Avenue~~ 124 South Euclid Avenue, 2nd Floor, Pierre, SD 57501, (605) 773-3563.

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 ~~2014~~ 2015 editions of the **Accounting Practices and Procedures Manual**, and the ~~2013~~ 2014 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.

General Authority: SDCL 58-6-75.

Law Implemented: SDCL 58-6-75.

References:

1. **Annual Statement Instructions - Life, Accident, and Health**, ~~2013~~ 2014 edition. Cost: $200.

2. **Annual Statement Instructions - Property and Casualty**, ~~2013~~ 2014 edition. Cost: $200.

3. **Annual Statement Instructions - Health**, ~~2013~~ 2014 edition. Cost: $200.

4. **Annual Statement Instructions - Title**, ~~2013~~ 2014 edition. Cost: $200

5. **Accounting Practices and Procedures Manual**, ~~2014~~ 2015. 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; 41 SDR 41, effective September 17, 2014.

General Authority: SDCL 58-6-75.

Law Implemented: SDCL 58-6-75.

Reference: Accounting Practices and Procedures Manual, Volumes I, II, and III ~~2014~~ 2015. 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.

General Authority: SDCL 58-6-75.

Law Implemented: SDCL 58-6-75.

Reference: Accounting Practices and Procedures Manual, Volumes I, II, and III ~~2014~~ 2015. 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**, ~~2013~~ 2014 edition and **Annual Statement Instructions - Property and Casualty**, ~~2013~~ 2014 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.

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**, ~~2013~~ 2014 edition. Cost: $200.

2. **Annual Statement Instructions - Property and Casualty**, ~~2013~~ 2014 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~~ Investment Analysis Office of the National Association of Insurance Commissioners**, December ~~2013~~ 2014 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.

General Authority: SDCL 58-27-108.

Law Implemented: SDCL 58-27-108.

Reference: Purposes and Procedures Manual of the ~~Securities Valuation~~ Investment Analysis Office of the National Association of Insurance Commissioners, ~~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: ~~$50~~ 100.

20:06:27:03. Requirements for use of HCFA Form 1500. The HCFA Form 1500 shall be used as follows:

(1) Health care practitioners, other than dentists, shall use the HCFA Form 1500, adopted by HCFA, approved by AMA Council on Medical Service in August, 1988, and in effect in May of 1995, when filing claims for professional services with issuers. Health care practitioners that bill patients directly shall provide a completed HCFA Form 1500 in addition to any other explanatory information used to bill the patient if requested by the patient. Issuers may only require health care practitioners to use the following coding systems for the initial filing of claims for health care services:

(a) HCPCS Level 1, Level 2, and Level 3 codes in effect as of June 30, 1995; and

(b) ICD-9-CM codes in effect as of June 30, 1995;

(2) Issuers may only require health care practitioners to use other explanations with a code or to furnish additional information with the initial submission of a HCFA Form 1500 under the following circumstances:

(a) If the procedure code used describes a treatment or service that is not otherwise classified;

(b) If the procedure code is followed by the CPT-4 modifier 22, 52, or 99, pursuant to the CPT-4 manual in effect as of June 30, 1995. Health care practitioners may use item 19 of the HCFA Form 1500 to explain multiple modifiers, unless box 19 is used for other purposes in accordance with the instructions for this form; or

(c) If information contained in the code is insufficient to process the claim or, in the case of a public program, is necessary to administer the program;

(3) Health care practitioners may use box 19 of the HCFA Form 1500 to indicate the form is an amended version of a form previously submitted to the issuer by inserting the word "amended" in the space provided;

(4) Except as otherwise required through participation in Medicaid, health care practitioners billing for services based on the amount of time involved shall define on line 19 the time interval in item 24 G of the HCFA Form 1500, if the time interval is not already defined in the HCPCS code. If not defined by either HCPCS or in line 19, the issuer shall assume units to be days of treatment;

(5) Except as otherwise required through participation in Medicaid, as authorized by Title XIX of the Social Security Act, 42 U.S.C. § 1396d, health care practitioners shall provide the unique physician identification number, as assigned by HCFA, in box 17a and the federal tax identification number or social security number to complete item 25 of the HCFA Form 1500.

Source: 22 SDR 97, effective December 18, 1995.

General Authority: SDCL 58-12-14.

Law Implemented: SDCL 58-12-12.

References: HCFA Form 1500 (12/90), in effect as of May, 1995, Health Care Financing Administration. Copies may be obtained from the American Medical Association, P.O. Box 7046, Dover, DE 19903-7046. Cost: Carton of 1,000, $67.95.

HCPCS Level 1 Codes: Physicians' Current Procedural Terminology (CPT '95), Fourth edition, revised 1994, American Medical Association. Copies may be obtained from

American Medical Association, P.O. Box 7046, Dover, DE 19903-7046. Cost: $41.95 each, plus shipping and handling.

HCPCS Level 2 Code: HCFA Common Procedure Coding System (HCPCS), (Alpha-Numeric Portion), January, 1995, Health Care Financing Administration, U.S. Department of Health and Human Services. Copies may be obtained from Superintendent of Documents, Publication Service Section 5505, Washington, DC 20402. Cost: $16 each.

Level 3 HCPCS Code: HCPCS 1995, November 7, 1994, pp. 161-163. Denver Region VIII, 00820 North Dakota B/S, Health Care Financing Administration, U.S. Department of Health and Human Services. Copies may be obtained from the South Dakota Division of Insurance, ~~500 East Capitol Avenue~~ 124 South Euclid Avenue, 2nd Floor, Pierre, SD 57501-5070. Cost: $.75 a page.

The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Fourth Edition, Volumes I and II, 1995: Context Software Systems, Inc., McGraw-Hill, Inc. Copies may be obtained from the American Medical Association, P.O. Box 7046, Dover, DE 19903-7046. Cost: $39.95 each, plus shipping and handling.

20:06:27:04. Requirements for use of HCFA Form 1450. The HCFA Form 1450 shall be used as follows:

(1) Institutional care practitioners shall use the HCFA Form UB-92 HCFA-1450, adopted by HCFA and in effect as of June 30, 1995, when filing claims for health care services with issuers. When requested by the patient, institutional care providers that bill patients directly shall provide a completed HCFA Form 1450 in addition to any other explanation or information used to bill the patient;

(2) Issuers may require institutional care practitioners to use only the following coding system for the initial filing of claims for health care services:

(a) ICD-9-CM codes, in effect as of June 30, 1995;

(b) Revenue codes, in effect as of June 30, 1995;

(c) HCPCS Level 1, Level 2, and Level 3 codes, in effect as of June 30, 1995; and

(d) The information outlined in subdivision 20:06:27:03(3), if the charges include direct service furnished by a health care practitioner and the direct service is not covered by the instructions for the HCFA Form 1450;

(3) Hospitals may use the HCFA Form 1500 to supplement a HCFA Form 1450 if necessary in billing patients or their representatives or filing claims with issuers for outpatient services.

Source: 22 SDR 97, effective December 18, 1995.

General Authority: SDCL 58-12-14.

Law Implemented: SDCL 58-12-12.

References: HCFA Form 1450: UB-92 HCFA-1450, in effect as of June 30, 1995, Health Care Financing Administration, U.S. Department of Health and Human Services. Copies may be obtained from the American Medical Association, P.O. Box 7046, Dover, DE 19903-7046. Cost: Carton of 1,000, $67.95.

The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Fourth Edition, Volumes I and II, 1995; Context Software Systems, Inc., McGraw-Hill, Inc. Copies may be obtained from the American Medical Association, P.O. Box 7046, Dover, DE 19903-7046. Cost: $39.95 each, plus shipping and handling.

Revenue Codes: UB-92, National Uniform Billing Data Element Specifications as Developed by the National Uniform Billing Committee as of January 8, 1993, effective October 1, 1993, Health Care Financing Administration, U.S. Department of Health and Human Services. Copies may be obtained from the South Dakota Division of Insurance, ~~500 East Capitol Avenue~~ 124 South Euclid Avenue, 2nd Floor, Pierre, SD 57501-5070. Cost: $.75 a page.

HCPCS Level 1 Codes: Physicians' Current Procedural Terminology (CPT 95), Fourth edition, revised 1994, American Medical Association. Copies may be obtained from American Medical Association, P.O. Box 7046, Dover, DE 19903-7046. Cost: $41.95 each, plus shipping and handling.

Level 2 HCPCS Code: HCFA Common Procedure Coding System (HCPCS), (Alpha-Numeric Portion), in effect as of January, 1995, Health Care Financing Administration, U.S. Department of Health and Human Services. Copies may be obtained from Superintendent of Documents, Publication Service Section 5505, Washington, DC 20402. Cost: $16 each.

Level 3 HCPCS Code: HCPCS 1995, November 7, 1994, pp. 161-163. Denver Region VIII, 00820 North Dakota B/S, Health Care Financing Administration, U.S. Department of Health and Human Services. Copies may be obtained from the South Dakota Division of Insurance, ~~500 East Capitol Avenue~~ 124 South Euclid Avenue, 2nd Floor, Pierre, SD 57501-5070. Cost: $.75 a page.

20:06:30:04. Formula for determining reserve interest rate adjustment. The associated formula for determining the reserve interest rate adjustment must reflect the ceding company's investment earnings and incorporate all realized and unrealized gains and losses reflected in the statutory statement. The following is an acceptable formula:

$$\text{Rate} = \frac{2\,(I + CG)}{X + Y - I - CG}$$

Where: I is the net investment income in Exhibit 2, line 16, column 7, page 10 of the Annual Statement for the year ended December 31, 1994;

CG is capital gains less capital losses in Exhibit 4, line 10, column 4, page 11 of the Annual Statement for the year ended December 31, 1994;

X is the current year cash and invested assets, page 2, line 10A, column 1, plus investment income due and accrued, page 2, line 16, column 1, less borrowed money, page 3, line 22, column 1, all in the Annual Statement for the year ended December 31, 1994; and

Y is the same as X but for the prior year.

Source: 22 SDR 52, effective October 25, 1995.

General Authority: SDCL 58-14-17.

Law Implemented: SDCL 58-14-17.

Reference: Life, Accident & Health Annual Statement for the Year Ended December 31, 1994, pages 2, 3, 10 and 11. National Association of Insurance Commissioners. Copies may be obtained from the South Dakota Division of Insurance, ~~118 West Capitol Avenue~~ 124 South Euclid Avenue, 2nd Floor, Pierre, SD 57501-2000, (605) 773-3563. Cost: $.75 a page.

20:06:30:08. Agreements -- Reporting of surplus increases. Any increase in surplus net of federal income tax resulting from arrangements described in § 20:06:30:07 must be identified separately on the insurer's financial statement required by SDCL 58-6-75 as a surplus item in aggregate write-ins for gains and losses in surplus in the Capital and Surplus Account, line 46, page 4 of the Annual Statement for the year ended December 31, 1994. Recognition of the

surplus increase as income must be reflected on a net of tax basis in "Commissions and expense allowances on reinsurance ceded," line 5, page 4 of the Annual Statement for the year ended December 31, 1994, as earnings emerge from the business reinsured. See the examples at the end of this section.

Source: 22 SDR 52, effective October 25, 1995.

General Authority: SDCL 58-14-17.

Law Implemented: SDCL 58-14-17.

Reference: Life, Accident & Health Annual Statement for the Year Ended December 31, 1994, page 4. National Association of Insurance Commissioners. Copies may be obtained from the South Dakota Division of Insurance, ~~118 West Capitol Avenue~~ 124 South Euclid Avenue, 2nd Floor, Pierre, SD 57501-2000, (605) 773-3563. Cost: $.75 a page.

Examples:

(1) On the last day of calendar year N, company XYZ pays a $20 million initial commission and expense allowance to company ABC for reinsuring an existing block of business. Assuming a 34 percent tax rate, the net increase in surplus at inception is $13.2 million ($20 million - $6.8 million) which is reported on page 4, line 46, "Aggregate write-ins for gains and losses in surplus" in the Capital and Surplus Account of the Annual Statement for the year ended December 31, 1994. $6.8 million (34% of $20 million) is reported as income on page 4, line 5, of the "Commissions and expense allowances on reinsurance ceded," line 5, of the Summary Operations of the Annual Statement for the year ended December 31, 1995.

(2) At the end of year N+1, the business has earned $4 million. Company ABC has paid $.5 million in profit and risk charges in arrears for the year and has received a $1 million experience refund. Company ABC's Annual Statement would report $1.65 million [66% of ($4

million - $1 million - $.5 million), up to a maximum of $13.2 million] on page 4, line 5, of "Commissions and expense allowances on reinsurance ceded," of the Summary of Operations of the Annual Statement for the year ended December 31, 1994, and - $1.65 million on page 4, line 46, on "Aggregate write-ins for gains and losses in surplus," of the Capital and Surplus Account of the Annual Statement for the Year Ended December 31, 1994. The experience refund would be reported separately as a miscellaneous income item in the Summary of Operations of the Annual Statement for the year ended December 31, 1994.

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 or any entity required to comply with RBC pursuant to § 58-4-48;

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

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

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

(7) "Health Organization," any health maintenance organization, limited health service organization, dental or vision plan, medical and dental indemnity or service corporation or other managed care organization licensed under SDCL 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," the National Association of Insurance Commissioners;

(9) "Life or health insurer," any insurance company licensed under SDCL 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," any insurance company licensed under SDCL Title 58 to do business in this state, but not monoline mortgage guaranty insurers, financial guaranty insurers, and title insurers;

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

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

(13) "RBC instructions," the 2013 **NAIC Life Risk-Based Capital Report**, the ~~2013~~ 2014 **NAIC Property and Casualty Risk-Based Capital Report**, and the ~~2013~~ 2014 **NAIC Health Risk-Based Capital Report**;

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

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

(16) "Total adjusted capital," 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.

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48.

References:

1. ~~**2013**~~ **2014 NAIC Life Risk-Based Capital Report.** Cost: $45.

2. ~~**2013**~~ **2014 NAIC Property and Casualty Risk-Based Capital Report**. Cost: $45.

3. ~~**2013**~~ **2014 NAIC Health Risk-Based Capital Report.** Cost: $45.

Copies of references 1 and 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.

20:06:44:01. Definitions. Terms used in this chapter mean:

(1) "Director," the director of the Division of Insurance, Department of ~~Commerce~~ Labor and Regulation;

(2) "Division," the Division of Insurance, Department of ~~Commerce~~ Labor and Regulation;

(3) "Department," the Department of ~~Commerce~~ Labor and Regulation;

(4) "Designee," the Department of ~~Commerce~~ Labor and Regulation, the attorney general, any state's attorney, any duly constituted criminal investigative department or agency of the state of South Dakota or of the United States, any county or municipal law enforcement agency having investigative jurisdiction, and any other person whose services are contracted for by the insurance fraud prevention unit;

(5) "Insurer," in addition to those persons defined under SDCL subdivision 58-1-2 (12), any person or entity transacting insurance with a certificate of authority issued by the director. The term also means health maintenance organizations, legal service insurance corporations, prepaid limited health service organizations, dental and other similar health service plans, and, notwithstanding SDCL subdivision 58-1-3 (1), fraternal benefit societies;

(6) "Criminal intelligence information," information associated with an identifiable individual, group, organization, or event, which information was compiled by a law enforcement agency in the course of conducting an investigation into a criminal conspiracy, projecting a potential criminal operation, or producing an estimate of future criminal activities; or in relation to the reliability of information derived from reports of informants or investigators or from any type of surveillance; and

(7) "Criminal investigative records," any document compiled or recorded pursuant to statutory authority that is associated with an individual, group, organization, or event, which record was compiled by a law enforcement agency in the course of conducting an investigation of a crime. This includes records or files about a crime derived from reports of officers, deputies, agents, informants, or investigators or from any type of surveillance.

Source: 26 SDR 109, effective March 5, 2000.

General Authority: SDCL 58-4A-13.

Law Implemented: SDCL 58-4A-13.

20:06:48:09. Appeals. If a claim is denied, the aggrieved party may appeal in writing to the claims administrator within 180 days of the date of the denial at the address listed on the explanation of benefits (EOB) or in the written utilization review denial. If the claims administrator again denies the claim, the aggrieved party may appeal in writing to the administrator of the risk pool, c/o the Bureau of Human Resources, ~~500 East Capitol Avenue~~ 124 South Euclid Avenue, 2nd Floor, Pierre, SD 57501, within 30 days of receiving notification of the denial. The administrator of the risk pool shall issue a written decision within 30 days from the date that the appeal is received. If the administrator of the risk pool denies the claim, the aggrieved party may appeal in writing to the risk pool board within 30 days of receiving notification of the denial and the board shall issue a written decision on the appeal. If the risk pool board denies the claim, the aggrieved party may request a hearing before the Office of Hearing Examiners within 30 days of receiving notification of the denial.

If the subject matter of the appeal is not a claim, the aggrieved party shall file an appeal directly to the administrator of the risk pool within 180 days of the date of the decision, and if not satisfied with the decision of the administrator of the risk pool, may appeal to the board within 30 days of the date of that decision. If the aggrieved party is not satisfied with the decision of the board, the aggrieved party may request a hearing before the Office of Hearing Examiners within 30 days of receiving notification of the board's decision.

Prior to the board hearing an appeal the chair of the risk pool board shall appoint a member of the board to serve as the final decision maker. The final decision maker may not participate in

the appeal or in any discussions related to the appeal. The final decision maker may accept, reject, or modify the findings, conclusions, and decisions of the hearing examiner pursuant to SDCL 1-26D-6. The aggrieved party may appeal any final decision to the circuit court in accordance with SDCL chapter 1-26.

If an aggrieved party fails to appeal within the time limits provided in this section, no further action is required.

Source: 30 SDR 51, effective October 28, 2003; 36 SDR 209, effective July 1, 2010; 39 SDR 100, effective December 6, 2012.

General Authority: SDCL 58-17-124(5)(7)(9).

Law Implemented: SDCL 58-17-124(5)(7)(9).

20:06:53:03. Notice of right to external review. A health carrier shall notify the covered person in writing of the covered person's right to request an external review to be conducted pursuant to §§ 20:06:53:12 to 20:06:53:53, inclusive, and include the appropriate statements and information set forth in this section at the same time the health carrier sends written notice of:

(1) An adverse determination upon completion of the health carrier's utilization review process set forth in SDCL 58-17H-1 to 58-17H-49, inclusive; and

(2) A final adverse determination.

As part of the written notice required by this section, a health carrier includes the following, or substantially equivalent, language: "We have denied your request for the provision of, or payment for, a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care

setting, level of care, or effectiveness of the health care service or treatment you requested by submitting a request for external review to the South Dakota Division of Insurance, ~~445 E. Capitol~~ 124 South Euclid Avenue, 2nd Floor, Pierre, South Dakota 57501." The notice as contained in Appendix A, or a substantially similar form as may be approved by the director, must be used.

Source: 37 SDR 48, effective September 22, 2010; 37 SDR 241, effective July 1, 2011.

General Authority: SDCL 58-17-87, 58-17H-49, 58-17I-16, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79.

DEPARTMENT OF LABOR AND REGULATION

DIVISION OF INSURANCE

MODEL NOTICE OF APPEAL RIGHTS

Chapter 20:06:53

APPENDIX A

SEE: § 20:06:53:03

Source: 37 SDR 48, effective September 22, 2010.

Appendix A -- Model Notice of Appeal Rights

NOTICE OF APPEAL RIGHTS

You have a right to appeal any decision we make that denies payment on your claim or your request for coverage of a health care service or treatment.

You may request more explanation when your claim or request for coverage of a health care service or treatment is denied or the health care service or treatment you received was not fully covered. Contact[1] us when you:

- Do not understand the reason for the denial;
- Do not understand why the health care service or treatment was not fully covered;
- Do not understand why a request for coverage of a health care service or treatment was denied;
- Cannot find the applicable provision in your Benefit Plan Document;
- Want a copy (free of charge) of the guidelines, criteria, or clinical rationale that we used to make our decision; or
- Disagree with the denial or the amount not covered and you want to appeal.

If your claim was denied due to missing or incomplete information, you or your health care provider may resubmit the claim to us with the necessary information to complete the claim.[1]

Appeals: All appeals for claim denials (or any decision that does not cover expenses you believe should have been covered) must be sent to [insert address of where appeals should be sent to the health carrier] within **180 days** of the date you receive our denial.[2] We will provide a full and fair review of your claim by individuals associated with us, but who were not involved in making the initial denial of your claim. You may provide us with additional information that relates to your claim and you may request copies of information that we have that pertains to your claims. We will notify you of our decision in writing within **60 days** of receiving your appeal.[3] If you do not receive our decision within **60 days** of receiving your appeal[3], you may be entitled to file a request for external review.[4]

External Review[4]: If we have denied your request for the provision of or payment for a health care service or course of treatment, you may have a right to have our decision reviewed by independent health care professionals who have no association with us. If our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment you requested, you may submit a request for external review within four months after receipt of this notice to the Division of Insurance, ~~445 E. Capitol Avenue~~ 124 South Euclid Avenue, 2nd Floor, Pierre, South Dakota 57501. For standard external review, a decision will be made within 45 days of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an expedited external review of our denial. If our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigation, you also may be entitled to file a request for external review of our denial. For details, please review your Benefit Plan Document, contact us, or contact your state insurance department.[1]

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[1] See address and telephone number on the enclosed Explanation of Benefits if you have questions about this notice.
[2] Unless your plan or any applicable state law allows you additional time.
[3] Some states and plans allow you more (or less) time to file an appeal and less (or more) time for our decision. See your Benefit Plan Document for your state's appeal process.
[4] See your Benefit Plan Document for your state's appeal process and to determine if you're eligible to request an external review in your state (e.g. some state appeal processes require you to complete your insurer's appeal process before filing an external review request unless waived by your insurer; while some states do not have such a requirement).

DEPARTMENT OF LABOR AND REGULATION

DIVISION OF INSURANCE

MODEL EXTERNAL REVIEW REQUEST FORM

Chapter 20:06:53

APPENDIX B

SEE: § 20:06:53:06

Source: 37 SDR 48, effective September 22, 2010.

Appendix B - Model External Review Request Form

This **EXTERNAL REVIEW REQUEST FORM** must be filed with the Division of Insurance within **FOUR MONTHS** after receipt from your insurer of a denial of payment on a claim or request for coverage of a health care service or treatment.

EXTERNAL REVIEW REQUEST FORM

APPLICANT NAME _____ ☐ Covered person/Patient ☐ Provider ☐ Authorized Representative

COVERED PERSON/PATIENT INFORMATION

Covered Person Name: _____
Patient Name: _____

Address: _____
_____
_____

Covered Person Phone #: Home (_____)_____
Work: (_____)_____

INSURANCE INFORMATION

Insurer/HMO Name
_____

Covered Person Insurance ID#:_____

Insurance Claim/Reference #:_____

Insurer/HMO Mailing Address:
_____
_____
_____

Insurer Telephone #:
(_____)_____

EMPLOYER INFORMATION

Employer's Name:
_____

Employer's Phone #:
(_____)_____

Is the health coverage you have through your employer a self-funded plan? _____. If you are not certain please check with your employer. Most self-funded plans are not eligible for external review. However, some self-funded plans may voluntarily provide external review, but may have different procedures. You should check with your employer.

HEALTH CARE PROVIDER INFORMATION

Treating Physician/Health Care Provider:
_____

Address:_____
_____
_____
Contact Person: _____
Phone: ( ) _____

Medical Record #: _____
REASON FOR HEALTH CARRIER DENIAL (Please check one)

☐ The health care service or treatment is not medically necessary.

☐ The health care service or treatment is experimental or investigational.

SUMMARY OF EXTERNAL REVIEW REQUEST (Enter a brief description of the claim, the request for health care service or treatment that was denied, and/or attach a copy of the denial from your health carrier)*
_____
_____
_____

*You may also describe in your own words the health care service or treatment in dispute and why you are appealing this denial using the attached pages below.

EXPEDITED REVIEW
If you need a fast decision, you may request that your external appeal be handled on an expedited basis. To complete this request, your treating health care provider must fill out the attached form stating that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.
Is this a request for an expedited appeal? Yes _____ No _____

SIGNATURE AND RELEASE OF MEDICAL RECORDS
To appeal your health carrier's denial, you must sign and date this external review request form and consent to the release of medical records.
I, _____, hereby request an external appeal. I attest that the information provided in this application is true and accurate to the best of my knowledge. I authorize my insurance company and my health care providers to release all relevant medical or treatment records to the independent review organization and the South Dakota Division of Insurance. I understand that the independent review organization and the South Dakota Division of Insurance will use this

information to make a determination on my external appeal and that the information will be kept confidential and not be released to anyone else. This release is valid for one year.

_____ _____

Signature of Covered Person (or legal representative)* Date

*(Parent, Guardian, Conservator or Other - Please Specify)

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

(Fill out this section only if someone else will be representing you in this appeal.)

You can represent yourself, or you may ask another person, including your treating health care provider, to act as your authorized representative. You may revoke this authorization at any time. I hereby authorize _____ to pursue my appeal on my behalf.

_____ _____

Signature of Covered Person (or legal representative)* Date

*(Parent, Guardian, Conservator or Other - Please Specify)

Address of Authorized Representative:

_____

_____

_____

Phone #.

Daytime (_____)_____

Evening (_____)_____

_____

HEALTH CARE SERVICE OR TREATMENT DECISION IN DISPUTE

DESCRIBE IN YOUR OWN WORDS THE DISAGREEMENT WITH YOUR HEALTH CARRIER. INDICATE CLEARLY THE SERVICE(S) BEING DENIED AND THE SPECIFIC DATE(S) BEING DENIED. EXPLAIN WHY YOU DISAGREE. ATTACH ADDITIONAL PAGES IF NECESSARY AND INCLUDE AVAILABLE PERTINENT MEDICAL RECORDS, ANY INFORMATION YOU RECEIVED FROM YOUR HEALTH CARRIER CONCERNING THE DENIAL, ANY PERTINENT PEER LITERATURE OR CLINICAL STUDIES, AND ANY ADDITIONAL INFORMATION FROM YOUR PHYSICIAN/HEALTH CARE PROVIDER THAT YOU WANT THE INDEPENDENT REVIEW ORGANIZATION REVIEWER TO CONSIDER.

WHAT TO SEND AND WHERE TO SEND IT

PLEASE CHECK BELOW (NOTE: YOUR REQUEST WILL NOT BE ACCEPTED FOR FULL REVIEW UNLESS ALL FOUR ITEMS BELOW ARE INCLUDED*)

1. ☐ **YES**, I have included this completed application form signed and dated;

2. ☐ **YES**, I have included a photocopy of my insurance identification card or other evidence showing that I am insured by the health insurance company named in this application;

3. ☐ **YES****, I have enclosed the letter from my health carrier or utilization review company that states:

(a) Their decision is final and that I have exhausted all internal review procedures; or
(b) They have waived the requirement to exhaust all of the health carrier's internal review procedures.

**You may make a request for external review without exhausting all internal review procedures under certain circumstances. You should contact the Division of Insurance, ~~445 E. Capitol Avenue~~ 124 South Euclid Avenue, 2nd Floor, Pierre, SD 57501.

4. ☐ **YES**, I have included a copy of my certificate of coverage or my insurance policy benefit booklet, which lists the benefits under my health benefit plan.

*Call the Division of Insurance at 605.773.3563 if you need help in completing this application or if you do not have one or more of the above items and would like information on alternative ways to complete your request for external review.

If you are requesting a standard external review, send all paperwork to:

South Dakota Division of Insurance
~~445 E Capitol Avenue~~ 124 South Euclid Avenue, 2nd Floor
Pierre, SD 57501

If you are requesting an expedited external review, call the Division of Insurance before sending your paperwork, and you will receive instructions on the quickest way to submit the application and supporting information.

CERTIFICATION OF TREATING HEALTH CARE PROVIDER FOR EXPEDITED CONSIDERATION OF A PATIENT'S EXTERNAL REVIEW APPEAL

NOTE TO THE TREATING HEALTH CARE PROVIDER

Patients can request an external review when a health center has denied a health care service or course of treatment on the basis of a utilization review determination that the requested health care service or course of treatment does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment you requested. The South Dakota Division of Insurance oversees external appeals. The standard external review process can take up to 45 days from the date the patient's request for external review is received by our division. Expedited external review is available only if the patient's treating health care provider certifies that adherence to the timeframe for the standard external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. An expedited external review must be completed within 72 hours. This form is for the purpose of providing the certification necessary to trigger expedited review.

GENERAL INFORMATION

Name of Treating Health Care Provider:
_____

Mailing Address:
_____
_____
_____

Phone Number: (_____)_____
Fax Number: (_____)_____

Licensure and Area of Clinical Specialty:
_____
_____

Name of Patient:
_____

Patient's Insurer Member ID#:
_____

CERTIFICATION

I hereby certify that: I am a treating health care provider for
_____
(hereafter referred to as "the patient"); that adherence to the timeframe of conducting a standard external review of the patient's appeal would, in my professional judgment, seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function; and that, for this reason, the patient's appeal of the denial by the patient's health carrier of the requested health care service or course of treatment should be processed on an expedited basis.

_____
Treating Health Care Provider's Name (Please Print)

_____ _____
Signature Date

PHYSICIAN CERTIFICATION
EXPERIMENTAL/INVESTIGATIONAL DENIALS
(To Be Completed by Treating Physician)

I hereby certify that I am the treating physician for _____ (insured's name) and that I have requested the authorization for a drug, device, procedure, or therapy denied for coverage due to the insurance company's determination that the proposed therapy is experimental and/or investigational. I understand that in order for the covered person to obtain the right to an external review of this denial, as treating physician I must certify that the insured's medical condition meets certain requirements:

In my medical opinion as the Insured's treating physician, I hereby certify to the following: (Please check all that apply) (NOTE: Requirements #1 - #3 below must all apply for the covered person to qualify for an external review).

☐ 1) The covered person has a terminal medical condition, life threatening condition, or a seriously debilitating condition.

☐ 2) The covered person has a condition that qualifies under one or more of the following: [please indicate which description(s) apply]:

☐ Standard health care services or treatments have not been effective in improving the covered person's condition;

☐ Standard health care services or treatments are not medically appropriate for the covered person; or

☐ There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the requested or recommended health care service or treatment.

☐ 3) The health care service or treatment I have recommended and which has been denied, in my medical opinion, is likely to be more beneficial to the covered person than any available standard health care services or treatments.

☐ 4) The health care service or treatment recommended would be significantly less effective if not promptly initiated.

Explain:_____
_____
_____

☐ 5) It is my medical opinion based on scientifically valid studies using accepted protocols that the health care service or treatment requested by the covered person and which has been denied is likely to be more beneficial to the covered person than any available standard health care services or treatments.

Explain:
_____
_____
_____

Please provide a description of the recommended or requested health care service or treatment that is the subject of the denial. (Attach additional sheets as necessary)

_____
_____

_____

Physician's Signature Date