CHAPTER 20:06:13

MEDICARE SUPPLEMENT INSURANCE

Section

20:06:13:17.03 Standards for basic core benefits for 1990 standardized Medicare supplement benefit plans.

20:06:13:17.04 Standards for additional benefits for 1990 standardized Medicare supplement benefit plans.

20:06:13:17.05 Requirements for standard Medicare supplement benefit plans.

20:06:13:17.06 Make-up of standardized benefit plans.

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20:06:13:17.08 Reinstitution of coverage following loss of eligibility for Medicaid.

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20:06:13:17.15 Make-up of standardized benefit plans -- Issued after May 31, 2010.

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20:06:13:30 Disclosure requirements for policies or subscriber contracts that are not Medicare supplement policies.

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20:06:13:77 Creditable coverage.

20:06:13:78 Medicare Advantage plan.

20:06:13:17.15. Make-up of standardized benefit plans -- Issued after May 31, 2010. The requirements for the make-up of standardized Medicare supplement benefit Plans A to L, inclusive, are as follows:

(1) Standardized Medicare supplement benefit Plan A shall include only the following: The core benefits as defined in § 20:06:13:17.12;

(2) Standardized Medicare supplement benefit Plan B shall include the following: The basic core benefit as defined in § 20:06:13:17.12, plus 100 percent of the Medicare Part A deductible as defined in § 20:06:13:17.13;

(3) Standardized Medicare supplement benefit Plan C shall include only the following: The basic core benefit as defined in § 20:06:13:17.12, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, one hundred percent of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in § 20:06:13:17.13;

(4) Standardized Medicare supplement benefit Part D shall include only the following: The core benefit as defined in § 20:06:13:17.12, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in § 20:06:13:17.13;

(5) Standardized Medicare supplement regular Plan F shall include only the following: The core benefit as defined in § 20:06:13:17.12, plus 100 percent of the Medicare Part A deductible, the skilled nursing facility care, one hundred percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in § 20:06:13:17.13;

(6) Standardized Medicare supplement Plan F with High Deductible shall include only the following: 100 percent of covered expenses following the payment of the annual deductible set forth in subsection (b):

(a) The basic core benefit as defined in § 20:06:13:17.12, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in § 20:06:13:17.12(1),(3),(4),(5), and (6);

(b) The annual deductible in Plan F with High Deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by regular Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be $1,500 and shall be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars;

(7) Standardized Medicare supplement benefit Plan G shall include only the following: The core benefit as defined in § 20:06:13:17.12, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, one hundred percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in § 20:06:13:17.13. After December 31, 2019, the standardized benefit plans described in 20:06:13:17.16(4) (redesignated Plan G High Deductible) may be offered to any individual who was eligible for Medicare after December 31, 2019;

(8) Standardized Medicare supplement Plan K, which is mandated by The Medicare Prescription Drug Improvement and Modernization Act of 2003, shall include only the following:

(a) Part A Hospital Coinsurance 61st through 90th days: Coverage of 100 percent of the Part A hospital coinsurance amount for each day used from the 61st to the 90th day, inclusive, in any Medicare benefit period;

(b) Part A Hospital Coinsurance, 91st through 150th days: Coverage of 100 percent of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st to the 150th day, inclusive, in any Medicare benefit period;

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

(d) Medicare Part A Deductible: Coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subsection (j);

(e) Skilled Nursing Facility Care: Coverage for 50 percent of the coinsurance amount for each day used from the 21st day to the 100th day, inclusive, in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A, until the out-of-pocket limitation is met as described in subsection (j);

(f) Hospice Care: Coverage for 50 percent of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subsection (j);

(g) Blood: Coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells, as defined under federal regulations 42 C.F.R. § 409.87(a) unless replaced in accordance with federal regulations 42 C.F.R. § 409.87(d) until the out-of-pocket limitation is met as described in subsection (j);

(h) Part B Cost Sharing: Except for coverage provided in subsection (i), coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in subsection (j);

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

(j) Cost Sharing after Out-of-Pocket Limits: Coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B or $4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services;

(9) Standardized Medicare supplement Plan L, which mandated by The Medicare Prescription Drug Improvement and Modernization Act of 2003, and shall include only the following:

(a) The benefits described in § 20:06:13:17.15(8)(a),(b),(c), and (i);

(b) The benefit described in § 20:06:13:17.15(8)(d),(e),(f),(g), and (h), but substituting 75 percent for 50 percent; and

(c) The benefit described in § 20:06:13:17.15(8)(j), but substituting $2000 for $4000;

(10) Standardized Medicare supplement Plan M shall include only the following: The core benefit as defined in § 20:06:13:17.12, plus 50 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in § 20:06:13:17.13;

(11) Standardized Medicare supplement Plan N shall include only the following: The basic core benefit as defined in § 20:06:13:17.12, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in § 20:06:13:17.13, with copayments in the following amounts:

(a) The lesser of $20 or the Medicare Part B coinsurance or copayment for each covered health care provider office visit, including visits to medical specialists; and (b) the lesser of fifty dollars or the Medicare Part B coinsurance or copayment for each covered emergency room visit. However, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

Source: 35 SDR 183, effective February 2, 2009; 36 SDR 209, effective July 1, 2010.

General Authority: SDCL 58-17A-2.

Law Implemented: SDCL 58-17A-2.

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

The standards and requirements of 20:06:13:17.14 and 20:06:13:17.15 shall apply to all Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare after December 31, 2019, with the following exceptions:

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

(2) Standardized Medicare supplement benefit Plan F is redesignated as Plan G and shall provide the benefits contained 20:06:13:17:15 (5) but shall not provide

coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible;

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

(4) Standardized Medicare supplement benefit Plan F With High Deductible is redesignated as Plan G With High Deductible and shall provide the benefits contained in 20:06:13:17:15(6) but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible, provided further that, the Medicare Part B deductible paid by the beneficiary shall be considered an out-of-pocket expense in meeting the annual high deductible.

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

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

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

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

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

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

Source:

General Authority: SDCL 58-17A-2.

Law Implemented: SDCL 58-17A-2.

DEPARTMENT OF LABOR AND REGULATION

DIVISION OF INSURANCE

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE POLICIES PLANS A THROUGH N

Chapter 20:06:13

APPENDIX D

SEE: § 20:06:13:36

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

APPENDIX D

[COMPANY NAME]

Outline of Medicare Supplement Coverage-Cover Page:

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

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

See Outlines of Coverage sections for details about ALL plans.

Basic Benefits:

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

- **Medical Expenses** -- Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.

- **Blood** -- First three pints of blood each year.

- **Hospice** -- Part A coinsurance.

A	B	C	D	F	F*	G
Basic, including 100% Part B coinsurance	Basic, Including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*		Basic, including 100% Part B coinsurance
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible
		Part B Deductible		Part B Deductible		
				Part B Excess (100%)		Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency

K	L	M	N
Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance except up to $20 copayment for office visit, and up to $50 copayment for ER
50% Skilled Nursing Facility Coinsurance 50% Part A Deductible	75% Skilled Nursing Facility Coinsurance 75% Part A Deductible	Skilled Nursing Facility Coinsurance 50% Part A Deductible	Skilled Nursing Facility Coinsurance Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit $[~~5120~~ 5240]; paid at 100% after limit reached	Out-of-pocket limit $[~~2560~~2620]; 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 $~~2200~~2,240 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $~~2200~~2,240. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

PREMIUM INFORMATION [Boldface Type]

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

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

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

RIGHT TO RETURN POLICY [Boldface Type]

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

POLICY REPLACEMENT [Boldface Type]

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

NOTICE [Boldface Type]

This policy may not fully cover all of your medical costs.

[for agents:]
Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]
[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare & You" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

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

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

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on

one chart. For purposes of illustration, charts for each plan are included in this chapter. An issuer may use additional benefit plan designations on these charts pursuant to § 20:06:13:17.05.]

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

Benefit Chart of Medicare Supplement Plans Sold after December 31, 2019

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

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

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Medicare Part B coinsurance or Copayment	✔	✔	✔	✔	50%	75%	✔	✔ copays apply[3]	✔	✔
Blood (first three pints)	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Part A hospice care coinsurance or copayment	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Skilled nursing facility coinsurance			✔	✔	50%	75%	✔	✔	✔	✔
Medicare Part A deductible		✔	✔	✔	50%	75%	50%	✔	✔	✔
Medicare Part B deductible									✔	✔
Medicare Part B excess charges				✔						✔
Foreign travel emergency (up to plan limits)			✔	✔			✔	✔	✔	✔
Out-of-pocket limit in [~~2016~~ 2018][2]					**[~~$4,960~~ $5,240][2]**	**[~~$2,480~~ $2,620][2]**				

1 Plans F and G also have a high deductible option which require first paying a plan deductible of [~~$2180~~ 2,240] before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

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

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[~~1316~~ 1,340]	$0	$[~~1316~~ 1,340] (Part A deductible)
61st thru 90th day	All but $[~~329~~ 335] a day	$[~~329~~ 335] a day	$0
91st day and after:			
--While using 60 lifetime reserve days		$[~~658~~ 670] a day	$0
--Once lifetime reserve days are used:	All but $[~~658~~ 670] 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 $[~~164.5~~167.50] a day	$0	Up to $[~~164.50~~167.50] 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 $[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
---Medically necessary skilled care services and medical supplies	100%	$0	$0
---Durable medical equipment			
First $[183] of Medicare approved amounts*	$0	$0	$[183] (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 $[~~1316~~ 1,340]	$[~~1316~~ 1,340] (Part A deductible)	$0
61st thru 90th day	All but $[~~329~~ 335] a day	$[~~329~~ 335] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[~~658~~ 670] a day	$[~~658~~ 670] 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 $[~~164.50~~ 167.50] a day	$0	Up to $[~~164.50~~ 167.50] 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 $[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
---Medically necessary skilled care services and medical supplies	100%	$0	$0
---Durable medical equipment			
First $[183] of Medicare approved amounts*	$0	$0	$[183] (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 $[~~1316~~ 1,340]	$[~~1316~~ 1,340] (Part A deductible)	$0
61st thru 90th day	All but $[~~329~~ 335] a day	$[~~329~~ 335] day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[~~658~~ 670] a day	$[~~658~~ 670] 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 $[~~164.50~~ 167.50] a day	Up to $[~~164.50~~ 167.50] 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 $[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
---Medically necessary skilled care services and medical supplies	100%	$0	$0
---Durable medical equipment			
First $[183] of Medicare approved amounts*	$0	$[183] (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 $[~~1316~~ 1,340]	$[~~1316~~ 1,340] (Part A deductible)	$0
61st thru 90th day	All but $[~~329~~ 335] a day	$[~~329~~ 335] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[~~658~~ 670] a day	$[~~658~~ 670] 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 $[~~164.50~~ 167.50] a day	Up to $[~~164.50~~ 167.50] 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 $[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies ---Durable medical equipment First $[183] of Medicare approved amounts* Remainder of Medicare approved amounts	 100% $0 80%	 $0 $0 20%	 $0 $[183] (Part B deductible) $0

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

PLAN F or HIGH DEDUCTIBLE PLAN F

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

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
**This high deductible plan pays the same benefits as Plan F after ~~one has~~ you have paid a calendar year $[~~2200~~ 2,240] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $[~~2200~~ 2,240]. 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 $[~~2200~~ 2,240] DEDUCTIBLE,** PLAN PAYS]	[IN ADDITION TO $[~~2200~~ 2,240] DEDUCTIBLE,** YOU PAY]
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[~~1316~~ 1,340]	$[~~1316~~ 1,340] (Part A	$0
61st thru 90th day	All but $[~~329~~ 335] a day	deductible) $[~~329~~ 335] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[~~658~~ 670] a day		$0
--Once lifetime reserve days are used:		$[~~658~~ 670] a day	
--Additional 365 days	$0		$0***
		100% of Medicare eligible	
--Beyond the additional 365 days	$0	expenses	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 $[~~164.50~~ 167.50] a day	Up to $[~~164.50~~ 167.50] a	$0
101st day and after	$0	day	All costs
		$0	
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN F or HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed $[183] 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 $[~~2200~~ 2,240] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $[~~2200~~ 2,240]. 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 $[~~2200~~ 2,240] DEDUCTIBLE,** PLAN PAYS]	[IN ADDITION TO $[~~2200~~ 2,240] DEDUCTIBLE,** YOU PAY]
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[183] of Medicare approved amounts*	$0	$[183] (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 $[183] of Medicare approved amounts*	$0	$[183] (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 $[~~2200~~ 2,240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[~~2200~~ 2,240] DEDUCTIBLE,**] YOU PAY'
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	$0	$0
---Durable medical equipment			
---First $[183] of Medicare approved amounts*	$0	$[183] (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 $[~~2200~~ 2,240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[~~2200~~ 2,240] DEDUCTIBLE,**] YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 life-time maximum

PLAN G or HIGH DEDUCTIBLE PLAN G

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

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
[**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year [$2,240] deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are [$2,240]. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[$2,240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2,240] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[~~1316~~ 1,340]	$[~~1316~~ 1,340] (Part A deductible)	$0
61st thru 90th day	All but $[~~329~~ 335] a day	$[~~329~~ 335] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[~~658~~ 670] a day	$[~~658~~ 670] 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 $[~~164.50~~ 167.50] a day	Up to $[~~164.50~~ 167.50] 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 or HIGH DEDUCTIBLE PLAN G

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

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

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2,240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2,240] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[183] of Medicare approved amounts*	$0	$0	$[183] (Unless Part B deductible has been met)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	0%
BLOOD			
First 3 pints	$0	All costs	$0
Next $[183] of Medicare approved amounts*	$0	$0	$[183] (Unless Part B deductible has been met)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES --TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2,240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2,240] DEDUCTIBLE,**] YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 life-time maximum

PLAN K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[~~5120~~ 5,240] 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 $[~~1316~~ 1,340]	$[~~658~~ 670] (50% of Part A deductible)	$[~~658~~ 670] (50% of Part A deductible)♦
61st thru 90th day	All but $[~~329~~ 335] a day	$[~~329~~ 335] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[~~658~~ 670] a day	$[~~658~~ 670] 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 $[~~164.50~~ 167.50] a day	Up to $[~~82.25~~ 83.75] a day (50% of Part A coinsurance)	Up to $[~~82.25~~ 83.75]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 $[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $[183] of Medicare approved amounts**** Preventative Benefits for Medicare covered services Remainder of Medicare approved amounts	 $0 Generally 80% or more of Medicare approved amounts Generally 80%	 $0 Remainder of Medicare approved amounts Generally 10%	 $[183] (Part B deductible)****♦ All costs above Medicare approved amounts Generally 10%
Part B Excess Charges (Above Medicare Approved Amounts)	$0	0%	All costs (and they do not count toward annual out-of-pocket limit of $[~~5120~~ 5,240])*
BLOOD First 3 pints Next $[183] of Medicare approved amounts**** Remainder of Medicare approved amounts	 $0 $0 Generally 80%	 50% $0 Generally 10%	 $50%♦ $[183] (Part B deductible)****♦ Generally 10%♦
CLINICAL LABORATORY SERVICES --TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[~~5120~~ 5,240] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies --Durable medical equipment First $[183] of Medicare approved amounts ***** Remainder of Medicare approved amounts	 100% $0 80%	 $0 $0 10%	 $0 $[183] (Part B deductible)♦ 10%♦

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

PLAN L

*You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[~~2560~~ 2,620] 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 $[~~1316~~ 1,340]	$[~~987~~ 1,005] (75% of Part A deductible)	$[~~329~~ 335] (25% of Part A deductible)♦
61st thru 90th day	All but $[~~329~~ 335] a day	$[~~329~~ 335] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[~~658~~ 670] a day	$[~~658~~ 670] 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 $[~~164.50~~ 167.50] a day	Up to $[~~123.38~~ 125.63] a day (75% of Part A Coinsurance)	Up to $[~~41.13~~ 41.88] a day (25% of Part A Coinsurance)♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	75%	25%♦
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	75% of copayment/coinsurance	25% of copayment/coinsurance ♦

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

PLAN L

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $[183] of Medicare approved amounts**** Preventative Benefits for Medicare covered services Remainder of Medicare approved amounts	 $0 Generally 80% or more of Medicare approved amounts Generally 80%	 $0 Remainder of Medicare approved amounts Generally 15%	 $[183] (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 $[~~2560~~ 2620])*
BLOOD First 3 pints Next $[183] of Medicare approved amounts**** Remainder of Medicare approved amounts	 $0 $0 Generally 80%	 75% $0 Generally 15%	 $25% $[183] (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 $[~~2560~~ 2620] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies --Durable medical equipment First $[183] of Medicare approved amounts ***** Remainder of Medicare approved amounts	 100% $0 80%	 $0 $0 15%	 $0 $[183] (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 $[~~1316~~ 1,340]	$[~~658~~ 670] (50% of Part A deductible)	$[~~658~~ 670] (50% of Part A deductible)
61st thru 90th day	All but $[~~329~~ 335] a day	$[~~329~~ 335] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[~~658~~ 670] a day	$[~~658~~ 670] 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 $[~~164.50~~ 167.50] a day	Up to $[~~164.50~~ 167.50] 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 M

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

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

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

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment			
First $[183] of Medicare approved amounts *	$0	$0	$[183] (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 $[~~1316~~ 1,340]	$[~~1316~~ 1,340] (Part A	$0
61st thru 90th day	All but $[~~329~~ 335] a day	deductible)	$0
91st day and after:		$[~~329~~ 335] a day	
--While using 60 lifetime reserve days	All but $[~~658~~ 670] a day	$[~~658~~ 670] 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 $[~~164.50~~ 167.50] a day	Up to $[~~164.50~~ 167.50] 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 N

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

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

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

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies --Durable medical equipment First $[183] of Medicare approved amounts* Remainder of Medicare approved amounts	100% $0 80%	$0 $0 20%	$0 $[183] (Part B deductible) $0

OTHER BENEFITS -- NOT COVERED BY MEDICARE

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

20:06:21:01.02. Service providers -- How defined. The policy or certificate shall contain definitions for all providers of services, including skilled nursing facilities, extended care facilities, convalescent nursing homes, personal care facilities, specialized care providers, assisted living facilities, and home health care agencies in relation to the services and facilities required to be available and the licensure, certification, or registration or degree status of those providing or supervising the services. When the definition requires that the provider be appropriately licensed, certified, or registered, it shall also state what requirements a provider must meet in lieu of licensure, certification or registration when the state in which the service is to be furnished does not require a provider of these services to be licensed, certified or registered, or when the other state licenses, certifies, or registers the provider of services under another classification.

Source: 22 SDR 97, effective December 18, 1995; 33 SDR 230, effective July 2, 2007.

General Authority: SDCL 58-17B-4.

Law Implemented: SDCL ~~28-6-38~~ 28-6-38(6), 58-17B-2, 58-17B-4.

20:06:21:23. Disclosure of renewability. Individual long-term care insurance policies shall contain a renewability provision. The provision must be captioned, must appear on the first page of the policy, and must clearly state ~~the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed~~ that the coverage is guaranteed renewable or noncancellable.

This section does not apply to policies under which the right to nonrenew is reserved solely to the policyholder and which do not contain a renewability provision. This paragraph applies to long-term care policies which are part of or combined with life insurance policies which do not contain renewability provisions.

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

General Authority: SDCL 58-17B-4.

Law Implemented: SDCL 58-17B-10.

20:06:21:26. Disclosure of other limitations or conditions on eligibility for benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in SDCL 58-17B-7 must contain a description of the limitations or conditions, including any required number of days of confinement in a separate paragraph of the policy or certificate, and shall clearly label the paragraph.

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

General Authority: SDCL 58-17B-4.

Law Implemented: SDCL 58-17B-7 and 58-17B-10.

20:06:21:28.01. Applications -- Questions about replacement. Application forms shall include questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and the agent, if any, containing the questions may be used. Unless coverage is direct marketed, the agent must ask and record the answers to all questions on the forms.

An insurer may complete or make contractual arrangements for persons other than agents to complete the appropriate application questions. The requirements of chapter 20:06:45 apply to such

arrangements. If an insurer uses a contractor or performs the service of completing the application, the contractor or person performing the service must ask the applicant the appropriate application questions and ~~such~~ the persons must record the applicant's responses to the questions in the application. While assisting the applicant in completing the application, a contractor is prohibited from attempting to sell or to interest the applicant in purchasing any product. The insurer is responsible for any failure to ask and accurately record the applicant's responses. ~~Nothing in this section in any way modifies the requirement for a person to hold an insurance agent license if that person sells, solicits, or negotiates insurance.~~

Nothing in this section in any way modifies the requirement for a person to hold an insurance agent license if that person sells, solicits, or negotiates insurance.

If the policy is a replacement policy issued to a group defined by SDCL 58-17A-1(6), the required questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificateholders have been notified of the replacement.

The questions required by this section are as follows:

(1) Do you have another long-term care insurance policy or certificate in force (including a health care service contract or a health maintenance organization contract)?

(2) Did you have another long-term care insurance policy or certificate in force during the last 12 months?

(a) If so, with which company?

(b) What is the expiration or "paid-to" date of that policy?

(c) If that policy lapsed, when did it lapse?

(3) Are you covered by Medicaid? and

(4) Do you intend to replace any of your medical or health insurance coverage with this policy (certificate)?

Agents must list any other health insurance policies they have sold to the applicant which are still in force and policies sold in the past five years which are no longer in force.

An insurer may delete the question in subdivision (2)(b) of this section from the application if the insurer either obtains the same information by means of a suitability form to be completed by the agent or obtains this information during the underwriting process.

Source: 23 SDR 55, effective October 20, 1996; 37 SDR 215, effective May 31, 2011; 39 SDR 10, effective August 1, 2012.

General Authority: SDCL 58-17B-4.

Law Implemented: SDCL 58-17B-4, 58-17B-5.1.

20:06:21:31. Standards for marketing -- Requirements. Each insurer, health care service plan, or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall:

(1) Establish marketing procedures and agent training requirements to assure that any comparison of policies by its agents or other producers will be fair and accurate;

(2) Establish marketing procedures and agent training requirements to assure that excessive insurance is not sold or issued;

(3) Display prominently by type, stamp, or other means, on the first page of the outline of coverage and policy the following: "Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations";

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance~~;~~, except in the case of qualified long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required;

(5) Establish auditable procedures for verifying compliance with this section; and

(6) Provide an explanation of contingent benefit upon lapse provided for in subdivision 20:06:21:58(4)(c) and, if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying periods in subdivision 20:06:21:58(4)(d).

If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program approved by the director in the state in which the certificate was issued, the insurer shall, at solicitation, provide written notice to the prospective policyholder or certificateholder that such a program is available and the name, address, and telephone number of the program.

Source: 22 SDR 97, effective December 18, 1995; 33 SDR 230, effective July 2, 2007.

General Authority: SDCL 58-17B-4.

Law Implemented: SDCL 58-17B-4, 58-17B-12.

20:06:21:32. Standards for marketing -- Prohibited practices. In addition to the practices prohibited in SDCL chapter 58-33, the following practices are prohibited:

(1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing or tending to induce a person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy or to take out a policy of insurance with another insurer;

(2) High pressure tactics. Employing any method of marketing inducing, having the effect of inducing, or tending to induce the purchase of insurance through force, fright, explicit or implied threat, or undue pressure to purchase or recommend the purchase of insurance; ~~and~~

(3) Cold lead advertising. Making use directly or indirectly of a method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company~~.~~; and

(4) Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

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

General Authority: SDCL 58-17B-4.

Law Implemented: SDCL 58-17B-1, 58-17B-12.

20:06:21:58. Nonforfeiture benefit requirement.

(1) This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

(2) To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of § 20:06:21:57:

(a) A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers, and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in subdivision (5) of this section; and

(b) The offer must be in writing if the nonforfeiture benefit is not otherwise described in the Outline of Coverage or other materials given to the prospective policyholder;

(3) If the offer required to be made under § 20:06:21:57 is rejected, the insurer shall provide the contingent benefit upon lapse described in this section. Even if this offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit on lapse in subdivision (4)(d) still applies;

(4)(a) After rejection of the offer required under § 20:06:21:57, for individual and group policies without nonforfeiture benefits issued after May 19, 2002, the insurer shall provide a contingent benefit upon lapse;

(b) In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate must provide either the nonforfeiture benefit or the contingent benefit upon lapse;

(c) The contingent benefit on lapse is triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least 30 days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase	
Issue Age	**Percent Increase Over Initial Premium**
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%

82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

(d) A contingent benefit on lapse is also triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insurer's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased, and the ratio in subdivision (4)(f)(ii) is 40 percent or more. Unless otherwise required, policyholders shall be notified at least 30 days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase	
	Percent Increase
Issue Age	Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

This provision is in addition to the contingent benefit lapse provided by subdivision (4)(c) and if both are triggered, the benefit provided shall be at the option of the insured;

(e) On or before the effective date of a substantial premium increase as defined in subdivision (4)(c) of this section, the insurer shall:

(i) Offer to reduce policy benefits provided by the current coverage ~~without the requirement of additional underwriting~~ consistent with the requirements of §20:06:21:86 so that required premium payments are not increased;

(ii) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of subdivision (5) of this section. This option may be elected at any time during the 120-day period referenced in subdivision (4)(c) of this section; and

(iii) Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in subdivision (4)(c) of this section is deemed to be the election of the offer to convert in subdivision (4)(d)(ii) of this section unless the automatic option in subdivision (4)(f)(iii) applies;

(f) On or before the effective date of a substantial premium increase as defined in subdivision (4)(d), the insurer shall;

(i) Offer to reduce policy benefits provided by the current coverage ~~without the requirement of additional underwriting~~ consistent with the requirements of §20:06:21:86 so that required premium payments are not increased;

(ii) Offer to convert the coverage to a paid-up status where the amount payable for each benefit is 90 percent of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the 120-day period referenced in subdivision (4)(d); and

(iii) Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in subdivision (4)(d) shall be deemed to be the election of the offer to convert in subdivision (4)(f)(ii) if the ratio is 40 percent or more;

(g) For any long-term care policy issued in this state, in the event the policy or certificate was issued at least twenty (20) years prior to the effective date of the increase, a value of 0% shall be used in place of all values in the above table, and values above 100% in the table in subdivision (4)(c) shall be reduced to 100%.

(5) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with subdivision (4)(c) but not subdivision (4)(d) of this section, are described in this subdivision:

(a) For purposes of subdivision (5), attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least one percent per year prior to age 50, and at least three percent per year beyond age 50;

(b) For purposes of subdivision (5), the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in subdivision (5)(c) of this section;

(c) The standard nonforfeiture credit will be equal to 100 percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit may not be less than 30

times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of subdivision (6) of this section;

(d) (i) The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three years as well as thereafter;

(ii) Notwithstanding subdivision (5)(d)(i) of this section, for a nonforfeiture benefit shall begin on the earlier of:

(1) The end of the tenth year following the policy or certificate issue date; or

(2) The end of the second year following the date the policy or certificate is no longer subject to attained age rating;

(e) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate;

(6) All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium paying status;

(7) There may be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies;

(8) The requirements set forth in this section shall become effective 12 months after adoption of this provision and shall apply as follows:

(a) Except as provided in ~~subdivision~~ subdivisions (8)(b) and (8)(c) of this section, the provisions of this section apply to any long-term care policy issued in this state on or after the effective date of this amended regulation;

(b) For certificates issued on or after May 19, 2002, ~~under~~ pursuant to a group long-term care insurance policy as defined in SDCL 58-17B-2(4)(a), which policy was in force at the time this amended regulation became effective, the provisions of this section shall not apply;

(c) The provisions of subdivision (3) relative to acceptance of an offer and subdivisions (4)(d) and (4)(f) apply to any long-term care insurance policy or certificate issued in this state after December 31, 2007, except for new certificates on a group policy as defined in subdivision (5)(a), for which the provisions apply after June 30, 2008;

(9) Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse are subject to the loss ratio requirements of § 20:06:21:05 or §§ 20:06:21:63 to 20:06:21:68, inclusive, whichever is applicable, treating the policy as a whole;

(10) To determine whether contingent nonforfeiture upon lapse provisions are triggered ~~under~~ pursuant to subdivision (4)(c) or subdivision (4)(d), a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer;

(11) A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:

(a) The nonforfeiture provision shall be appropriately captioned;

(b) The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the director for the same contract form; and

(c) The nonforfeiture provision shall provide at least one of the following:

(i) Reduced paid-up insurance;

(ii) Extended term insurance;

(iii) Shortened benefit period; or

(iv) Other similar offerings approved by the director.

Source: 28 SDR 157, effective May 19, 2002; 30 SDR 39, effective September 28, 2003; 33 SDR 230, effective July 2, 2007.

General Authority: SDCL 58-17B-4.

Law Implemented: SDCL 58-17B-4.

20:06:21:61. Initial filing requirements.

(1) This section applies to any long-term care policy issued in this state on or after November 1, 2002;

(2) An insurer shall provide the information listed in this section to the director 30 days prior to making a long-term care insurance form available for sale:

(a) A copy of the disclosure documents required in § 20:06:21:60; and

(b) An actuarial certification consisting of at least the following:

(i) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

(ii) A statement that the policy design and coverage provided have been reviewed and taken into consideration;

(iii) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

(iv) A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

(I) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

(II) A statement that the assumptions used for reserves contain reasonable margins for adverse experience;

(III) A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted); and

(IV) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur;

(A) An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;

(B) If the gross premiums for certain age groups appear to be inconsistent with this requirement, the director may request a demonstration under subdivision (3) of this section based on a standard age distribution; and

(v)(I) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or

(II) A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences;

(vi) A statement that the premiums contain at least the minimum margin for moderately adverse experience defined in subdivision (2)(b)(vi)(I) or the specification of and justification for a lower margin as required by subdivision (2)(b)(vi)(II).

(I) A composite margin shall not be less than 10% of lifetime claims.

(II) A composite margin that is less than 10% may be justified in uncommon circumstances. The proposed amount, full justification of the proposed amount, and methods to monitor developing experience that would be the bases for withdrawal of approval for such lower margins must be submitted.

(III) A composite margin lower than otherwise considered appropriate for the stand-alone long-term care policy may be justified for long-term care benefits provided through a life policy or an annuity contract. This lower composite margin, if utilized, shall be justified by the appropriate actuarial demonstration addressing margins and volatility when considering the entirety of the product.

(IV) A greater margin may be appropriate in circumstances where the company has less credible experience to support its assumptions used to determine the premium rate.

(c) An actuarial memorandum prepared, dated and signed by a member of the Academy of Actuaries shall be included and shall address and support each specific item required as part of the actuarial certification and provide at least the following information:

(i) An explanation of the review performed by the actuary prior to making the statements in subdivisions (2)(b)(ii) and (iii);

(ii) A complete description of pricing assumptions;

(iii) Sources and levels of margins incorporated into the gross premiums that are the basis for the statement in subdivision (2)(b)(i) of the actuarial certification and an explanation of the analysis and testing performed in determining the sufficiency of the margins. Deviations in margins between ages, sexes, plans or states shall be clearly described. Deviations in margins required to be described are other than those produced utilizing generally accepted actuarial methods for smoothing and interpolating gross premium sales; and

(iv) A demonstration that the gross premiums include the minimum composite margin specified in subdivision (2)(b)(vi).

(3)~~(a) The director may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both;~~

~~(b) In the event the director asks for additional information under this provision, the period in subdivision (1) of this section does not include the period during which the insurer is preparing the requested information.~~ In any review of the actuarial certification and actuarial memorandum, the director may request review by an actuary with experience in long-term care pricing who is independent of the company. In the event the director asks for additional information as a result of any review, the period in subdivision (1) of this section does not include the period during which the insurer is preparing the requested information.

Source: 28 SDR 157, effective May 19, 2002.

General Authority: SDCL 58-17B-4.

Law Implemented: SDCL 58-17B-4.

20:06:21:63. Premium rate schedule increases -- Notice of pending increase. An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the director at least 30 days prior to the notice to the policyholders, and shall include:

(1) Information required by § 20:06:21:60;

(2) Certification by a qualified actuary that:

(a) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;

(b) The premium rate filing is in compliance with the provisions of this section;

(c) The insurer may request a premium rate schedule increase less than what is required under this section and the director may approve such premium rate schedule increase, without submission of the

certification in subdivision (2)(a), if the actuarial memorandum discloses the premium rate schedule increase necessary to make the certification required pursuant to subdivision (2)(a), the premium rate schedule increase filing satisfies all other requirements of this section, and is, in the opinion of the director, in the best interest of the policyholders;

(3) An actuarial memorandum justifying the rate schedule change request that includes:

(a) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase~~;~~ and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;

(i) Annual values for the five years preceding the three years following the valuation date shall be provided separately;

(ii) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(iii) The projections shall demonstrate compliance with § 20:06:21:64; and

(iv) For exceptional increases:

(I) The projected experience must be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

(II) In the event the director determines as provided in § 20:06:21:70 that offsets may exist, the insurer shall use appropriate net projected experience;

(b) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

(c) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

(d) A statement that policy design, underwriting, and claims adjudication practices have been taken into consideration; and

(e) In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates;

(f) A demonstration that actual and projected costs exceed costs anticipated at the time of initial pricing under moderately adverse experience and that the composite margin specified in subdivision 20:06:21:61(2)(b)(iv) is projected to be exhausted;

(4) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the director; and

(5) Sufficient information for review and approval of the premium rate schedule increase by the director.

Source: 28 SDR 157, effective May 19, 2002.

General Authority: SDCL 58-17B-4.

Law Implemented: SDCL 58-17B-4.

20:06:21:64. Premium rate schedule increase requirements. All premium rate schedule increases shall be determined in accordance with the following requirements:

(1) Exceptional increases shall provide that 70 ~~percent~~% of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(2) Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(a) The accumulated value of the initial earned premium times 58 ~~percent~~%;

(b) ~~Eighty-five percent~~ 85% of the accumulated value of prior premium rate schedule increases on an earned basis;

(c) The present value of future projected initial earned premiums times ~~58 percent~~58%; and

(d) ~~Eighty-five percent~~85% of the present value of future projected premiums not in subdivision (2)(c) of this section on an earned basis;

(3) In the event that a policy form has both exceptional and other increases, the values in ~~subdivision~~subdivisions (2)(b) and (d) of this section will also include 70 ~~percent~~% for exceptional rate increase amounts; and

(4) All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in SDCL 58-26-71 and 58-26-75. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages~~.~~;

(5) After December 31, 2018, expected claims shall be calculated based on the original filing assumptions assumed until new assumptions are filed as part of a rate increase. New assumptions shall be used for all periods beyond each requested effective date of a rate increase. Expected claims are calculated for each calendar year based on the in-force at the beginning of the calendar year. Expected claims shall include

margins for moderately adverse experience, either amounts included in the claims that were used to determine the lifetime loss ration consistent with the original filing or as modified in any rate increase filing.

Source: 28 SDR 157, effective May 19, 2002.

General Authority: SDCL 58-17B-4.

Law Implemented: SDCL 58-17B-4.

20:06:21:65. Premium rate schedule increases - Review by the director. For each rate increase that is implemented, the insurer shall file for approval by the director updated projections, as defined in subdivision 20:06:21:63(3)(a), annually for the next three years and include a comparison of actual results to projected values. The director may extend the period to greater than three (3) years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in § 20:06:21:68, the projections required by this chapter shall be provided to the policyholder in lieu of filing with the director.

(1) If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in subdivision 20:06:21:63(3)(a), shall be filed for approval by the director every five years following the end of the required period in the above paragraph. For group insurance policies that meet the conditions in § 20:06:21:68, the projections required by this subdivision shall be provided to the policyholder in lieu of filing with the director;

(2)(a) If the director has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse

conditions demonstrate that incurred claims will not exceed proportions of premiums specified in § 20:06:21:64, the director may require the insurer to implement any of the following:

(i) Premium rate schedule adjustments; or

(ii) Other measures to reduce the difference between the projected and actual experience;

(b) In determining whether the actual experience adequately matches the projected experience, consideration must be given to subdivision 20:06:21:63(3)(e), if applicable;

(3) If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

(a) A plan, subject to director approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the director may impose the condition in subdivisions 20:06:21:66(1) and (2); and

(b) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to § 20:06:21:64 had the greater of the original anticipated lifetime loss ratio or 58 ~~percent~~% been used in the calculations described in ~~subdivision~~ subdivisions 20:06:21:64(2)(a) and (c).

After December 31, 2018, subdivision 3(b) is no longer applicable.

Source: 28 SDR 157, effective May 19, 2002.

General Authority: SDCL 58-17B-4.

Law Implemented: SDCL 58-17B-4.

20:06:21:67. Premium rate schedule increases - Policies to which does not apply. Sections 20:06:21:63 to 20:06:21:66, inclusive, shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in subdivision ~~20:06:21:01(10)~~ 20:06:21:01(13), if the policy complies with all of the following provisions:

(1) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(2) The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in SDCL 58-15-31 and 58-15-72, and for variable annuities those nonforfeiture requirements as may be approved by the director;

(3) The policy meets the disclosure requirements of §§ 20:06:21:44, 20:06:21:47, and 20:06:21:48;

(4) The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:

(a) Policy illustrations as required by chapter 20:06:38;

(b) If long-term care benefits are funded through an annuity, the disclosure requirements are:

(i) The insurer must provide to all prospective purchasers a Buyer's Guide to Annuities and a Contract Summary, prior to accepting the applicants initial consideration, unless the annuity contract or associated life insurance policy provides for an unconditional refund period of at least ten days or unless the Contract Summary contains an unconditional refund offer;

(ii) The insurer shall provide a Buyer's Guide to Annuities and a Contract Summary to any prospective purchaser upon request;

(iii) A preneed funeral contract or prearrangement which is funded by an annuity contract shall be adequately disclosed at the time of application, prior to accepting the initial consideration. All relevant information shall be disclosed, including but not limited to merchandise, services, penalties or restrictions, impact of any changes in the annuity contract, relationship among agent(s), provider, and administrator; and

(c) Disclosure requirements in § 20:06:07:05;

(5) An actuarial memorandum is filed with the insurance department that includes:

(a) A description of the basis on which the long-term care rates were determined;

(b) A description of the basis for the reserves;

(c) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(d) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(e) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(f) The estimated average annual premium per policy and the average issue age;

(g) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the

type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(h) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

Source: 28 SDR 157, effective May 19, 2002; 36 SDR 209, effective July 1, 2010.

General Authority: SDCL 58-17B-4.

Law Implemented: SDCL 58-17B-4.

20:06:21:76. Long-term care partnership policies -- Inflation protection requirements. An insurer may not issue a policy intended to qualify as a partnership policy unless in addition to the requirements of §§ 20:06:21:06 to 20:06:21:06.05, inclusive, the policy includes the following inflation protection:

(1) For a person who is less than 61 years of age as of the date of purchase, the policy provides compound annual inflation protection; and

(2) For a person who is at least 61 years of age but less than 76 years of age, the policy provides some level of inflation protection that may not be less than ~~three~~ one percent per year or a rate equal to the Consumer Price Index.

Inflation protection as required by this section may not be less than ~~three~~ one percent per year or a rate equal to the Consumer Price Index. For any person who has attained the age of 76, inflation protection may be provided but is not required.

Source: 33 SDR 230, effective July 2, 2007; 34 SDR 88, effective September 10, 2007.

General Authority: SDCL 58-17B-4.

Law Implemented: SDCL ~~28-6-38~~28-6-38(6), 58-17B-4.

20:06:21:86. Right to reduce coverage and lower premiums. Each long-term care insurance policy and certificate shall include a provision that allows the policyholder or certificateholder to reduce coverage and lower the policy or certificate premium in at least one of the following ways:

(1) Reducing the maximum benefit; or

(2) Reducing the daily, weekly, or monthly benefit amount.

The insurer may also offer other reduction options that are consistent with the policy or certificate design or the carrier's administrative processes. In the event the reduction in coverage involves the reduction or elimination of the inflation protection provision, the insurer shall allow the policyholder to continue the benefit amount in effect at the time of the reduction. The provision shall include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage. ~~The age to determine the premium for the reduced coverage shall be based on the age used to determine the premiums for the coverage currently in force.~~

The premium for the reduced coverage shall be based on the same age and underwriting class used to determine the premium for the coverage currently in force and be consistent with the approved rate table.

The insurer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable. If a policy or certificate is about to lapse, the insurer shall provide a written reminder to the policyholder or

certificateholder of his or her right to reduce coverage and premiums in the notice required by § 20:06:21:22.

This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

A premium increased notice required by subdivision 20:06:21:60(5) shall include:

(1) An offer to reduce policy benefits provided by the current coverage consistent with the requirements of this section;

(2) A disclosure stating that all options available to the policyholder may not be of equal value; and

(3) In the case of a partnership policy, a disclosure that some benefit reduction options may result in a loss in partnership status that may reduce policyholder protections.

Source: 33 SDR 230, effective July 2, 2007.

General Authority: SDCL 58-17B-4.

Law Implemented: SDCL 58-17B-4.

20:06:21:104. Applicability. The requirements of §§ 20:06:21:87 to 20:06:21:103, inclusive, apply to a benefit trigger request made after December 31, 2010, under a long-term care insurance policy.

As used for purposes of independent review, a benefit trigger is a contractual provision in the insured's long-term care insurance conditioning the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. For purposes of a tax-qualified long term care insurance contract as defined in Section 7702B of the Internal Revenue Code of 1986, as amended, a benefit trigger shall include a determination by a licensed health care practitioner that an insured is a chronically ill individual.

Source: 36 SDR 209, effective July 1, 2010.

General Authority: SDCL 58-17B-4.

Law Implemented: SDCL 58-17B-4.

DEPARTMENT OF LABOR AND REGULATION

DIVISION OF INSURANCE

PERSONAL WORKSHEET

Chapter 20:06:21

APPENDIX E

SEE: § 20:06:21:53.02

Source: 28 SDR 157, effective May 19, 2002.

Long-Term Care Insurance

Personal Worksheet

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and **ask** you fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Numbers _____

The premium for the coverage you are considering will be [$ _____ per month, or $ _____ per year,] [a one-time single premium of $ _____.]

Type of Policy (noncancellable / guaranteed renewable):

_____

_____

The Company's Right to Increase Premiums:

_____

_____

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] [Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.]

Rate Increase History

The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long-term care policy it has sold in this state or any other state.] [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years.] [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increases.]

Questions Related to Your Income

How will you pay each year's premium?

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

[☐ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?]

What is your annual income? (check one) ☐ Under $10,000 ☐ $[10-20,000] ☐ $[20-30,000] ☐ $[30-50,000] ☐ Over $50,000

How do you expect your income to change over the next 10 years? (check one)

☐ No change ☐ Increase ☐ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) ☐ Yes ☐ No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount? ☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

The national average annual cost of care in [insert year] was [insert $ amount], but this figure varies across the county. In ten years the national average annual cost would be about [insert $ amount] if costs increase 5% annually.

What elimination period are you considering? Number of days _____ Approximate cost $_____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

☐ Under $20,000 ☐ $20,000-$30,000 ☐ $30,000-$50,000 ☐ Over $50,000

How do you expect your assets to change over the next ten years? (check one)

☐ Stay about the same ☐ Increase ☐ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

☐ The answers to the questions above describe my financial situation.

or

☐

I choose not to complete this information. (Check one)
☐ I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. **I understand that the rates for this policy may increase in the future.** (This box must be checked.

Signed: _____ _____

(Applicant) (Date)

[☐ I explained to the applicant the importance of completing this information.

Signed: _____ _____

(Agent) (Date)

Agent's Printed Name: _____]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed: _____ _____]

~~(Applicant) (Date)~~

Long-Term Care Insurance
Personal Worksheet

Drafting Note: Companies shall at a minimum provide all of the information shown below and in the same order. The company may include additional information related to this long-term care insurance coverage in relevant and readable language. Bracketed statements indicate the companies should choose the applicable statement, are allowed flexibility in inserting numerical ranges, etc.

Long-Term Care Insurance Personal Worksheet

This worksheet will help you understand some important information about this type of insurance. State law requires companies issuing this [policy] [certificate] [rider] to **give** you some important facts about premiums and premium increases and to **ask** you some important questions to help you and the company decide if you should buy this [policy] [certificate] [rider]. Long-term care insurance can be expensive and it may not be right for everyone.

Premium Information

The premium for the coverage you are considering will be [$ per [insert payment interval] **or a total of**
[$ per year] [a one-time single premium of $].

The premium quoted in this worksheet is not guaranteed and may change during the underwriting process and in the future while this [policy] [certificate] [rider] is in force.

Drafting Note: Companies will insert payment interval - monthly, quarterly, etc. and the appropriate dollar amount.

Type of Policy & The Company's Right to Increase Premiums on the Coverage You Choose:

[Noncancellable - The company **cannot** increase your premiums on this [policy] [certificate] [rider]].

[Guaranteed renewable - The company **can** increase your premiums on this [policy] [certificate][rider] in the future if it increases the premiums for all [policies] [certificates] [riders] like yours in this state.]

[Paid-up - This [policy] [certificate] [rider] will be paid-up after you have paid all of the premiums specified in your [policy] [certificate] [rider]].

Drafting Note: Companies will insert the appropriate policy type and the associated bracketed statement. Premium guarantees shall not be shown on this form.

Premium Increase History

[Name of company] has sold long-term care insurance since [year] and has sold this [policy] [certificate] [rider] since [year].

[The company has never increased its premiums for any long-term care [policy] [certificate] [rider] it has sold in this state or any other state.]

[The company has not increased its premiums for this [policy] [certificate] [rider] or similar [policies] [certificates] [riders] in this state or any other state in the last 10 years.]

[The company has increased its premiums on this [policy] [certificate] [rider] or similar [policies] [certificates] [riders] in the last 10 years. A summary of those premium increases follows.

Drafting Note: If the summary of premium increases is extensive, the company may disclose the required premium increase history via an addendum attached to this worksheet. The company may substitute the language below for the last sentence in the paragraph above and include the full summary as an attachment to this worksheet.

"Over the past 3 years, the company has increased premiums by _ %." "A summary of premium increases in the last 10 years is attached to this worksheet".

Companies that have increased premiums by 30% or more in the last ten years must include the following statement: "There was a 30% or greater premium
increase in [insert year]." "A summary of premium increases in the last 10 years is attached to this worksheet."

Questions About Your Income

You do **not** have to answer the questions that follow. They are intended to make sure you have thought about how you'll pay premiums and the cost of care your insurance does not cover. If you do not want to answer these questions, you should understand that the company might refuse to insure you.

What resources will you use to pay your premium?
O Current income from employment O Current income from investments O Other current income O Savings O Sell investments O Sell other assets O Money from my family O Other____

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this [policy} [certificate] [rider] if the premiums will be more than 7% of your income.

Could you afford to keep this [policy] [certificate] [rider] if your spouse or partner dies first?
O Yes O No O Had not thought about it O Do not know O Does not apply

[What would you do if the premiums went up, for example, by 50%?
O Pay the higher premium O Call the company/agent O Reduce benefits O Drop the **[policy] [certificate] [rider]** O Do not know]

Drafting Note: The company is not required to use the bracketed question above if the coverage is fully paid up or is noncancellable.

What is your household annual income from all sources? (check one)
O [Less than $10,000] O $[10,000-19,999] O $[20,000-29,999] O $(30,000-50,000] O [More than $50,000]

Drafting Note: The companies may choose the income ranges to put in the brackets to fit its suitability standards.

Do you expect your income to change over the next 10 years?
(check one)
O No O Yes, expect increase O Yes, expect decrease

If you plan to pay premiums from your income, have you thought about how a change in your income would affect your ability to continue to pay the premium?
O Yes O No O Do not know

Will you buy inflation protection?
(check one) O Yes O No

Inflation may increase the cost of long-term care in the future.
If you do not buy inflation protection, how will you pay for the difference between future costs and your daily benefit amount?
O From my income O From savings O From investments O Sell other assets O Money from my family O Other

The national average annual cost of long-term care in [insert year] was [insert $ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert$ amount] if costs increase 5% annually.

Drafting Note: The projected cost can be based on federal estimates in a current year. This figure should also be used when calculating the cost of long-term care in the "approximate cost $____ for that period of care" question found below. In the above statement, the second figure will equal 163% of the first figure.

What [elimination period] [waiting period] [cash deductible] are you considering?

[Number of days _____ in [elimination period][waiting period]

Approximate cost of care for this period: $_____
($xxx per day times number of days in [elimination period] [waiting period], where "xxx" represents the most recent estimate of the national daily average cost of long-term care)]

[Cash Deductible $ _____].

How do you plan to pay for your care during the [elimination period] [waiting period] [deductible period]? (check all that apply)
O From my income O From my savings/investments O My family will pay

Questions About Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)
O [Less than $20 ,000] O [$20 ,000 -$29 ,999] O [$30 ,000 -$49,999] O [More than $50,000]

Drafting Note: Companies may choose the asset ranges to put in the brackets to fit its suitability standards.

Do you expect the value of your assets to change over the next ten years? (check one)
O No O Yes, expect to increase O Yes, expect to decrease

If you're buying this [policy] [certificate] [rider] to protect your assets and your assets are less than $50,000, experts suggest you think about other ways to pay for your long-term care.

Disclosure Statement

O The answers to the questions above describe my financial situation.
Or
O I choose not to complete this information. (Check one.)

O I agree that the company and/or its agent (below) has reviewed this worksheet with me including the premium, premium increase history and potential for premium increases in the future. I understand the information contained in this worksheet. (This box must be checked.)
Drafting Note: For direct mail situations, the lead sentence should be changed to "I agree that I have reviewed this worksheet including the premium…"

Signed:

_____

(Applicant) (Date)

[O] I explained to the applicant the importance of answering these questions.

Signed: _____

(Agent) (Date)

Agent's Printed Name: _____]

[In order for us to process your application, please return this signed worksheet to [name of company], along with your application.]

[My agent has advised me that this long-term care insurance [policy] [certificate] [rider] does not seem to be suitable for me. However, I still want the company to consider my application.

Signed: _____ .]

(Applicant) (Date)

Drafting Note: Choose the appropriate sentences depending on whether this is a direct mail or agent sale.

Someone from the company may contact you to discuss your answers and the suitability of this [policy] [ce1tificate] [rider] for you.

Drafting Note: When the Long-Term Care Insurance Personal Worksheet is furnished to

employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the page may be removed.

DEPARTMENT OF LABOR AND REGULATION

DIVISION OF INSURANCE

POTENTIAL RATE INCREASE DISCLOSURE FORM

Chapter 20:06:21

APPENDIX I

SEE: § 20:06:21:60

Source: 28 SDR 157, effective May 19, 2002; 33 SDR 230, effective July 2, 2007.

Instructions:

This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

Insurers shall provide all of the following information to the applicant;

Long-Term Care Insurance

Potential Rate Increase Disclosure Form

1. **[Premium Rate] [Premium Rate Schedules]**: [Premium rate] [Premium rate schedules] that [is] [are] applicable to you and that will be in effect until a request is made and [filed] [approved] for an increase [is] [are] [on the application] [$_____].

2. **The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.**

3. **Rate Schedule Adjustments:**

The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): _____.

4. **Potential Rate Revisions:**

This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

~~**If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:**~~

- ~~Pay the increased premium and continue your policy in force as is.~~
- ~~Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)~~
- ~~Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.~~
- ~~Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)~~

Instructions: *Insurers shall provide all of the following information to the applicant regarding premium, premium adjustments, potential premium increases, and policyholder options in the event of a premium increase except as noted below. This form does not need to be provided in the event the policy does not reserve the right to increase rates.*

As used in this Appendix:

"Policy," is a policy, certificate, or rider, as applicable.
"Premium," includes premium schedules, as applicable.
Companies may substitute whichever term is appropriate to reflect the long-term care insurance for which the applicant is applying.

Long-Term Care Insurance
Potential Premium Increase Disclosure Form

Important Notice: Your long-term care insurance company **may** increase the premium for your policy **every year.** You have certain rights and it's important that you understand them before you buy a long-term care insurance policy. Please read this information and be sure you understand it before you buy a policy.

This policy is guaranteed renewable. *Companies can increase the premiums for guaranteed renewable policies in the future. The company* ***cannot*** *increase your premiums*

*because **you are** older or **your** health declines. It can increase premiums based on the experience of all individuals with a policy like yours.*

1. **What Is Your Premium?**

   The agent/company has quoted you a premium of [$ _____] for this policy. This is not **a** final premium. The premium might change during the underwriting process or if you choose different benefits. The premium you'll be required to pay for your policy will be [shown on the schedule page of] [will be attached to] your policy.

2. **How Will I Know If My Premium Is Changing?**

   The company will send you a notice. The notice will include the new premium and when you will start paying it. It also will give you ways you could avoid paying a higher premium. One likely choice will be to keep your insurance policy, but with fewer or lower benefits than you bought. Another choice may be to stop paying premiums and have a "paid-up" policy with fewer or lower benefits than the policy you bought. You may have other choices.

*** Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.

- In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).

- Your "paid-up" policy benefits are $10,000 (provided you have at least $10,000 of benefits remaining under your policy).

Contingent Nonforfeiture
Cumulative Premium Increase over Initial Premium
That Qualifies for Contingent Nonforfeiture

(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%

81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

[The following contingent nonforfeiture disclosure need only be included for those limited pay policies to which §§ 20:06:21:58(4)(d) and 20:06:21:58(4)(f) are applicable.]

In addition to the contingent nonforfeiture benefits described above, the following reduced "paid-up" contingent nonforfeiture benefit is an option in all policies that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit when you bought your policy. If both the reduced "paid up" benefit AND the contingent benefit described above are triggered by the same rate increase, you can choose either of the two benefits.

You are eligible for the reduced "paid-up" contingent nonforfeiture benefit if all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below:

Triggers for a Substantial Premium Increase	
Issue Age	**Percent Increase Over Initial Premium**
Under 65	50%
65-80	30%
Over 80	10%

2. You stop paying your premiums within 120 days of when the premium increase took effect; AND

3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If you exercise this option your coverage will be converted to reduced "paid-up" status. That means there will be no additional premiums required. Your benefits will change in the following ways:

a. The total lifetime amount of benefits your reduced paid up policy will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the policy becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.

b. The daily benefit amounts you purchased will also be adjusted by the same ratio.

If you purchased lifetime benefits, only the daily benefit amounts you purchased will be adjusted by the applicable ratio.

Example:

- You bought the policy at age 65 with an annual premium payable for 10 years.

- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.

- Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your "paid-up" policy benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced "paid-up" policy.

20:06:22:29. Rating area. No health insurance issuer may vary rates based on geographical location in this state except as permitted by this section. The rating areas are on a county basis and are as follows:

(1) Harding, Butte, Perkins, ~~Corson, Dewey,~~ Ziebach, Haakon, Jackson, Bennett, Oglala Lakota, Fall River, Custer, Pennington, Lawrence, Meade, ~~Stanley,~~ Jones, ~~Lyman,~~ Mellette, and Todd~~, Tripp, and Gregory~~;

(2) Lake, Moody, McCook, Minnehaha, Turner, Lincoln, Clay, and Union;

(3) Campbell, Corson, Dewey, Walworth, Potter, McPherson, Edmunds, Faulk, Brown, Spink, Marshall, Roberts, Day, Grant, Codington, Clark, Hamlin, Deuel, Brookings, Kingsbury, and Beadle; and

(4) Sully, Hughes, Hyde, Hand, Buffalo, Jerauld, Sanborn, Lyman Miner, Brule, Aurora, Davison, Hanson, Douglas, Charles Mix, Hutchinson, Bon Homme, Stanley, Tripp, Gregory and Yankton.

Nothing in this section requires a health insurance issuer to use a different geographic rating factor for each rating area. A health insurance issuer may assign the same rating band for any or all of the rating areas specified in this section.

Source: 39 SDR 203, effective June 10, 2013; SL 2015, ch 56, § 1, effective May 1, 2015.

General Authority: SDCL 58-17-4.2, 58-17-87, 58-18B-18, 58-18B-36.

Law Implemented: SDCL ~~58-17-4.3~~58-17-74.1, 58-17-87, 58-18B-18, 58-18B-36.

20:08:05:25. Custody requirements for investment advisers. It is unlawful and deemed to be a fraudulent, deceptive, or manipulative act, practice, or course of business for an investment adviser to have custody of client funds or securities unless:

(1) The investment adviser notifies the director promptly in writing that the investment adviser has or may have custody. ~~Such~~ This notification is required to be given on Form ADV;

(2) Qualified custodian. A qualified custodian maintains those funds and securities:

(a) In a separate account for each client under the client's name; or

(b) In accounts that contain only the adviser's clients' funds and securities, under the adviser's name as agent or trustee for the clients.

(3) If an investment adviser opens an account with a qualified custodian on its client's behalf, either under the client's name or under the name of the investment adviser as agent, the investment adviser must notify the client in writing of the qualified custodian's name, address, and the manner in which the funds or securities are maintained, promptly when the account is opened and following any changes to this information.

(4) Account statements must be sent to clients, either:

(a) By a qualified custodian when the investment adviser has a reasonable basis for believing that the qualified custodian sends an account statement, at least quarterly, to each client for which it maintains funds or securities, identifying the amount of funds and of each security in the account at the end of the period and setting forth all transactions in the account during that period; or

(b) By the investment adviser who sends an account statement, at least quarterly, to each client for whom the investment adviser has custody of funds or securities, identifying the amount

of funds and of each security of which the investment adviser has custody at the end of the period and setting forth all transactions during that period; and

(c) An independent certified public accountant verifies all client funds and securities by actual examination at least once during each calendar year at a time chosen by the accountant without prior notice or announcement to the adviser and that is irregular from year to year, and files a copy of the special examination report with the director within 30 days after the completion of the examination, along with a letter stating that it has examined the funds and securities and describing the nature and extent of the examination; and

(d) The independent certified public accountant, upon finding any material discrepancies during the course of the examination, notifies the director within one business day of the finding, by means of a facsimile transmission or electronic mail, followed by first class mail, directed to the attention of the director.

(5) Special rule for limited partnerships and limited liability companies. If the adviser is a general partner of a limited partnership (or managing member of a limited liability company, or hold a comparable position for another type of pooled investment vehicle), the account statements required in § 20:08:05:25(4) must be sent to each limited partner (or member or other beneficial owner or their independent representative).

(6) Independent representatives. A client may designate an independent representative to receive, on the client's behalf, notices and account statements as required under § 20:08:05:25(3) and (4).

(7) Direct fee deduction. An investment adviser who has custody as defined in § 20:08:05:25(11)(a)(i)(B) by having fees directly deducted from client accounts must also provide the following safeguards:

(a) The investment adviser must have written authorization from the client to deduct advisory fees from the account held with the qualified custodian;

(b) Each time a fee is directly deducted from a client account, the investment adviser must concurrently:

(i) Send the qualified custodian an invoice of the amount of the fee to be deducted from the client's account; and

(ii) Send the client an invoice itemizing the fee. Itemization includes the formula used to calculate the fee, the amount of assets under management the fee is based on, and the time period covered by the fee.

(c) The investment adviser notifies the director in writing that the investment adviser intends to use the safeguards provided in § 20:08:05:25(7)(a) and (b). Such notification is required to be given on Form ADV.

(d) An investment adviser having custody solely because it meets the definition of custody as defined in § 20:08:05:25(11)(a)(i)(B) and who complies with the safekeeping requirements in § 20:08:05:25(1) to (7), inclusive, will not be required to meet the financial requirements for custodial advisers as set forth in § 20:08:05:21 and 20:08:05:22(1) or the bonding requirement as set forth in § 20:08:05:24.

(8) Pooled investments. An investment adviser who has custody as defined in § 20:08:05:25(11)(a)(i)(C) and who does not meet the exception provided under

§ 20:08:05:25(10)(c) must, in addition to the safeguards set forth in § 20:08:05:25(1) to (5), inclusive, also comply with the following:

(a) Hire an independent party to review all fees, expenses, and capital withdrawals from the pooled accounts;

(b) Send all invoices or receipts to the independent party, detailing the amount of the fee, expenses, or capital withdrawal and the method of calculation such that the independent party can:

(i) Determine that the payment is in accordance with the pooled investment vehicle standards (generally the partnership agreement or membership agreement); and

(ii) Forward, to the qualified custodian, approval for payment of the invoice with a copy to the investment adviser.

(c) For purposes of § 20:08:05:25, the phrase, independent party, means a person that:

(i) Is engaged by the investment adviser to act as a gatekeeper for the payment of fees, expenses, and capital withdrawals from the pooled investment;

(ii) Does not control and is not controlled by and is not under common control with the investment adviser; and

(iii) Does not have, and has not had within the past two years, a material business relationship with the investment adviser.

(d) The investment adviser notifies the director in writing that the investment adviser intends to use the safeguards provided in § 20:08:05:25(1) to (8)(d), inclusive. ~~Such~~ This notification is required to be given on Form ADV.

(e) An investment adviser having custody solely because it meets the definition of custody as defined in § 20:08:05:25(11)(a)(i)(C) and who complies with the safekeeping requirements in § 20:08:05:25(1) to (6), inclusive, and (8) will not be required to meet the financial requirements for custodial investment advisers as set forth in § 20:08:05:21 and 20:08:05:22 or the bonding requirement as set forth in § 20:08:05:24.

(9) Investment adviser or investment adviser representative as trustee. When a trust retains an investment adviser; investment adviser representative; or employee, director, or owner of an investment adviser as trustee and the investment adviser acts as the investment adviser to that trust, the investment adviser will:

(a) Notify the director in writing that the investment adviser intends to use the safeguards provided in § 20:08:05:25(9) and (10). ~~Such~~This notification is required to be given on Form ADV; and

(b) Send to the grantor of the trust, the attorney for the trust if it is a testamentary trust, the co-trustee (other than the investment adviser; investment adviser representative; or employee, director, or owner of the investment adviser); or a defined beneficiary of the trust, at the same time that it sends any invoice to the qualified custodian, an invoice showing the amount of the trustees' fee or investment management or advisory fee, the value of the assets on which the fees were based, and the specific manner in which the fees were calculated; and

(c) Enter into a written agreement with a qualified custodian which specifies:

(i) That the qualified custodian will not deliver trust securities to the investment adviser, any investment adviser representative, or employee, director, or owner of the investment

adviser, nor will transmit any funds to the investment adviser; any investment adviser representative or employee; director or owner of the investment adviser, except that the qualified custodian may pay trustees' fees to the trustee and investment management or advisory fees to investment adviser, if:

(A) The grantor of the trust or attorneys for the trust, if it is a testamentary trust, the co-trustee (other than the investment adviser; investment adviser representative; or employee, director or owner of the investment adviser); or a defined beneficiary of the trust has authorized the qualified custodian in writing to pay those fees;

(B) The statements for those fees show the amount of the fees for the trustee and, in the case of statements for investment management or advisory fees, show the value of the trust assets on which the fee is based and the manner in which the fee was calculated; and

(C) The qualified custodian agrees to send to the grantor of the trust, the attorneys for a testamentary trust, the co-trustee (other than the investment adviser; investment adviser representative; or employee, director or owner of the investment adviser); or a defined beneficiary of the trust, at least quarterly, a statement of all disbursements from the account of the trust, including the amount of investment management fees paid to the investment adviser and the amount of trustees' fees paid to the trustee.

(ii) Except as otherwise set forth in § 20:08:05:25(9)(c)(ii), that the qualified custodian may transfer funds or securities, or both, of the trust only upon the direction of the trustee (who may be the investment adviser; investment adviser representative; or employee, director, or owner of the investment adviser), who the investment adviser has duly accepted as an authorized signatory. The grantor of the trust or attorneys for the trust, if it is a testamentary trust, the co-trustee (other than the investment adviser; investment adviser representative; or employee,

director, or owner of the investment adviser); or a defined beneficiary of the trust, must designate the authorized signatory for management of the trust. The direction to transfer funds or securities, or both, can only be made to the following:

(A) A trust company, bank trust department, or brokerage firm independent of the investment adviser for the account of the trust to which the assets relate;

(B) The named grantors or to the named beneficiaries of the trust;

(C) A third party independent of the investment adviser in payment of the fees or charges of the third party including:

(a) Attorney's, accountant's, or qualified custodian's fees for the trust; and

(b) Taxes, interest, maintenance or other expenses, if there is property other than securities or cash owned by the trust;

(D) Third parties independent of the investment adviser for any other purpose legitimately associated with the management of the trust; or

(E) A broker-dealer in the normal course of portfolio purchases and sales, if the transfer is made on payment against delivery basis or payment against trust receipt.

(d) Not be required to meet the financial requirements for custodial advisers as set forth in §§ 20:08:05:21 and 20:08:05:22(1) or the bonding requirements as set forth in § 20:08:05:24 if the investment adviser has custody solely because it meets the definition of custody as defined in § 20:08:05:25(11)(a)(i)(C) and who complies with the safekeeping requirements in § 20:08:05:25(1) to (6), inclusive, and (9).

(10) Exceptions.

(a) Shares of mutual funds. With respect to shares of an open-end company as defined in Section 5(a)(1) of the Investment Company Act of 1940 ("mutual fund"), the investment adviser may use the mutual fund's transfer agent in lieu of a qualified custodian for purposes of complying with § 20:08:05:25(1) to (9), inclusive;

(b) Certain privately offered securities.

(i) The investment adviser is not required to comply with § 20:08:05:25(1) to (9), inclusive, with respect to securities that are:

(A) Acquired from the issuer in a transaction or chain of transactions not involving any public offering;

(B) Uncertificated and ownership thereof is recorded only on books of the issuer or its transfer agent in the name of the client; and

(C) Transferable only with prior consent of the issuer or holders of the outstanding securities of the issuer.

(ii) Notwithstanding § 20:08:05:25(10)(b)(i), the provisions of § 20:08:05:25(10)(b)(ii) are available with respect to securities held for the account of a limited partnership (or limited liability company, or other type of pooled investment vehicle) only if the limited partnership is audited, the audited financial statements are distributed, as described in § 20:08:05:25(10)(c) and the investment adviser notifies the director in writing that the investment

adviser intends to provide audited financial statements, as described above. ~~Such~~ This notification is required to be given on Form ADV.

(c) Limited partnerships subject to annual audit. An investment adviser is not required to comply with § 20:08:05:25(4) with respect to the account of a limited partnership (or limited liability company, or another type of pooled investment vehicle) that is subject to an audit at least annually and distributes its audited financial statements prepared in accordance with generally accepted accounting principles to all limited partners (or members or other beneficial owners) within 120 days of the end of its fiscal year. The investment adviser must also notify the director in writing that the investment adviser intends to employ the use of the audit safeguards described above. ~~Such~~ This notification is required to be given on Form ADV.

(d) Registered investment companies. The investment adviser is not required to comply with § 20:08:05:25 with respect to the account of an investment company registered under the Investment Company Act of 1940.

(e) Beneficial trusts. An investment adviser is not required to comply with safekeeping requirements of § 20:08:05:25(1) to (9), inclusive, or the Net Worth and Bonding Requirements of §§ 20:08:05:21, 20:08:05:22(1) and 20:08:05:24 if the investment adviser has custody solely because the investment adviser, investment adviser representative, or employee, director, or owner of the investment adviser is a trustee for a beneficial trust, if all of the following conditions are met for each trust:

(i) The beneficial owner of the trust is a parent, a grandparent, a spouse, a sibling, a child, or a grandchild of the trustee. These relationships shall include step relationships.

(ii) For each account under this § 20:08:05:25(10)(e)(i) above, the investment adviser complies with the following:

(A) The investment adviser provides a written statement to each beneficial owner of the account setting forth a description of the requirements of § 20:08:05:25 (1) to (9), inclusive, and the reasons why investment adviser will not be complying with those requirements.

(B) The investment adviser obtains from each beneficial owner a signed and dated statement acknowledging the receipt of the written statement required under § 20:08:05:25(10)(e)(ii)(A).

(C) The investment adviser maintains a copy of both documents described in § 20:08:05:25(10)(e)(ii)(A) and (B) until the account is closed or the investment adviser is no longer trustee.

(f) Any investment adviser who intends to have custody of client funds or securities but is not able to utilize a qualified custodian as defined in § 20:08:05:25(11)(c) ~~must~~ shall first obtain approval from the director and must comply with all of the applicable safekeeping provisions under § 20:08:05:25(1) to (9), inclusive, including taking responsibility for those provisions that are designated to be performed by a qualified custodian.

(11) Definitions. For the purposes of § 20:08:05:25:

(a) "Custody," ~~means~~ holding directly or indirectly, client funds or securities, or having any authority to obtain possession of them or has the ability to appropriate them~~.~~;

(i) Custody includes:

(A) Possession of client funds or securities unless received inadvertently and returned to the sender promptly, but in any case within three business days of receiving them;

(B) Any arrangement (including a general power of attorney) under which the investment adviser is authorized or permitted to withdraw client funds or securities maintained with a custodian upon the investment adviser's instruction to the custodian; and

(C) Any capacity (such as general partner of a limited partnership, managing member of a limited liability company, or a comparable position for another type of pooled investment vehicle, or trustee of a trust) that gives the investment adviser or its supervised person legal ownership of or access to client funds or securities.

(ii) Receipt of checks drawn by clients and made payable to unrelated third parties will not meet the definition of custody if forwarded to the third party within 24 hours of receipt and the adviser maintains a ledger or other listing of all securities or funds held or obtained, including the following information:

(A) Issuer;

(B) Type of security and series;

(C) Date of issue;

(D) For debt instruments, the denomination, interest rate, and maturity date;

(E) Certificate number, including alphabetical prefix or suffix;

(F) Name in which registered;

(G) Date given to the adviser;

(H) Date sent to client or sender;

(I) Form of delivery to client or sender, or copy of the form of delivery to client or sender; and

(J) Mail confirmation number, if applicable, or confirmation by client or sender of the fund's or security's return.

(b) "Independent representative," ~~means~~ a person who:

(i) Acts as agent for an advisory client, including in the case of a pooled investment vehicle, for limited partners of a limited partnership, members of a limited liability company, or other beneficial owners of another type of pooled investment vehicle and by law or contract is obliged to act in the best interest of the advisory client or the limited partners, members, or other beneficial owners;

(ii) Does not control, is not controlled by, and is not under common control with investment adviser; and

(iii) Does not have, and has not had within the past two years, a material business relationship with the investment adviser.

(c) "Qualified custodian," ~~means~~ the following independent institutions or entities that are not affiliated with the investment adviser by any direct or indirect common control and have not had a material business relationship with the investment adviser in the previous two years:

(i) A bank or savings association that has deposits insured by the Federal Deposit Insurance Corporation under the Federal Deposit Insurance Act or other entity pursuant to 15 U.S.C. § 80b-2(a)(2), as of January 1, 2018;

(ii) A registered broker-dealer holding the client assets in customer accounts;

(iii) A registered futures commission merchant registered under Section 4f(a) of the Commodity Exchange Act, holding the client assets in customer accounts, but only with respect to clients' funds and security futures, or other securities incidental to transactions in contracts for the purchase or sale of a commodity for future delivery and options thereon; and

(iv) A foreign financial institution that customarily holds financial assets for its customers, if the foreign financial institution keeps the advisory clients' assets in customer accounts segregated from its proprietary assets.

Source: 37 SDR 112, effective December 9, 2010.

General Authority: SDCL 47-31B-411(f), 47-31B-605(a)(1) to (3), inclusive.

Law Implemented: SDCL 47-31B-103, 47-31B-411(f).