ARTICLE 20:06

INSURANCE

Chapter

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CHAPTER 20:06:36

RISK-BASED CAPITAL (RBC) REPORTS

Section

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

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

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

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

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

~~(4)~~(5) "Foreign insurer," any insurance company which is licensed to do business in this state but is not domiciled in this state;

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

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

~~(5)~~(8) "NAIC," the National Association of Insurance Commissioners;

~~(6)~~(9) "Life or health insurer," any insurance company licensed ~~to do business in this state~~ under SDCL Title 58 to write life or health, or a property and casualty insurer licensed to do business in this state writing only accident and health insurance;

~~(7)~~ (10) "Property and casualty insurer," any insurance company licensed under SDCL Title 58 to do business in this state, but not monoline mortgage guaranty insurers, financial guaranty insurers, and title insurers;

~~(8)~~ (11) "Negative trend," for a life or health insurer, a negative trend in the level of risk-based capital over a period of time;

~~(9)~~(12) "RBC," risk-based capital;

~~(10)~~(13) "RBC instructions," the 2013 **NAIC Life Risk-Based Capital Report**, the 2013 **NAIC Property and Casualty Risk-Based Capital Report**, and the 2013 **NAIC Health Risk-Based Capital Report**;

~~(11)~~ (14) "RBC plan," a comprehensive financial plan containing the elements specified in § 20:06:36:08. If the director rejects the RBC plan and it is revised by the insurer or health organization, with or without the director's recommendation, the plan is called the "revised RBC plan";

~~(12)~~ (15) "RBC report," the report required in §§ 20:06:36:03 to 20:06:36:06, inclusive;

~~(13)~~ (16) "Total adjusted capital," the sum of an insurer's or health organization's statutory capital and surplus as determined in accordance with the statutory accounting applicable to the annual financial statements required to be filed under SDCL 58-6-75, and any other items required by the RBC instructions.

Source: 23 SDR 228, effective July 3, 1997; 25 SDR 13, effective August 9, 1998; 26 SDR 26, effective September 1, 1999; 27 SDR 54, effective December 4, 2000; 30 SDR

39, effective September 28, 2003; 31 SDR 21, effective August 23, 2004; 33 SDR 59, effective October 5, 2006; 34 SDR 271, effective May 6, 2008; 35 SDR 165, effective December 22, 2008; 36 SDR 209, effective July 1, 2010; 37 SDR 241, effective July 1, 2011; 38 SDR 219, effective June 25, 2012; 39 SDR 219, effective June 26, 2013; 41 SDR 41, effective September 17, 2014.

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48.

References:

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

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

20:06:36:03. RBC reports. As required by SDCL 58-4-48, each domestic insurer or domestic health organization shall file by March 1 a report of its RBC levels as of the end of the calendar year just ended, in a form and containing the information required by the RBC instructions.

Each domestic insurer or domestic health organization shall file its RBC report with the NAIC in accordance with the RBC instructions and with the insurance director in any state in which the insurer or health organization is authorized to do business if that insurance director has requested in writing that the report be filed. If a request is made, the insurer or health

organization shall file its RBC report by the later of 15 days from the receipt of notice to file its RBC report with that state or the filing date.

Source: 23 SDR 228, effective July 3, 1997.

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48.

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

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

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

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

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

Source: Source: 23 SDR 228, effective July 3, 1997; 25 SDR 13, effective August 9, 1998; 26 SDR 26, effective September 1, 1999; 27 SDR 54, effective December 4, 2000; 30 SDR 39, effective September 28, 2003; 31 SDR 21, effective August 23, 2004; 33 SDR 59, effective October 5, 2006; 34 SDR 271, effective May 6, 2008; 35 SDR 165, effective December 22, 2008; 36 SDR 209, effective July 1, 2010; 37 SDR 241, effective July 1, 2011; 38 SDR 219, effective June 25, 2012; 39 SDR 219, effective June 26, 2013; 41 SDR 41, effective September 17, 2014.

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48.

~~**References**:~~

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

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

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

20:06:36:05. Property and casualty insurer's and health organization's RBC reports. A property and casualty insurer's or health organization's RBC report shall be determined in accordance with the formula set forth in the RBC instructions ~~in the 2013 NAIC Property and Casualty Risk-Based Capital Report~~. The formula shall take into account, and may adjust for the covariance between, the following factors determined in each case by applying the factors in the manner set forth in the RBC instructions:

(1) Asset risk;

(2) Credit risk;

(3) Underwriting risk; and

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

Source: 23 SDR 228, effective July 3, 1997; 25 SDR 13, effective August 9, 1998; 26 SDR 26, effective September 1, 1999; 27 SDR 54, effective December 4, 2000; 30 SDR 39, effective September 28, 2003; 31 SDR 21, effective August 23, 2004; 33 SDR 59, effective October 5, 2006; 34 SDR 271, effective May 6, 2008; 35 SDR 165, effective December 22,

2008; 36 SDR 209, effective July 1, 2010; 37 SDR 241, effective July 1, 2011; 38 SDR 219, effective June 25, 2012; 39 SDR 219, effective June 26, 2013; 41 SDR 41, effective September 17, 2014.

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48.

~~**Reference:** 2013 NAIC Property and Casualty Risk-Based Capital Report; National Association of Insurance Commissioners. Copies may be obtained from the NAIC, 1100 Walnut Street, Ste. 1500, Kansas City, MO 64106-2197, (816) 783-8300; http://www.naic.org. Cost: $45.~~

20:06:36:06. Adjusted RBC report. If a domestic insurer or domestic health organization files an RBC report which in the judgment of the director is inaccurate, the director shall adjust the RBC report to correct the inaccuracy and shall notify the insurer or health organization of the adjustment. The notice shall contain a statement of the reason for the adjustment. An RBC report so adjusted is referred to as an adjusted RBC report.

Source: 23 SDR 228, effective July 3, 1997.

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48.

20:06:36:07. Company action level event. A company action level event is any of the following events:

(1) The filing of an RBC report by an insurer or health organization which indicates one of the following:

(a) The insurer's or health organization's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC;

(b) If the insurer is a life or health insurer, the insurer has total adjusted capital which is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and ~~2.5~~ 3.0 and has a negative trend. A negative trend is determined in accordance with the trend test calculation in the Life RBC instructions; ~~or~~

(c) If the insurer is a property and casualty insurer, the insurer has total adjusted capital which is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the property and casualty RBC instructions; or

(d) If a health organization, the health organization has a total adjusted capital which is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the health RBC instructions.

(2) The notice by the director to the insurer or health organization of an adjusted RBC report that indicates an event in subdivision (1) of this section, and the insurer or health organization does not challenge the adjusted RBC report under § 20:06:36:21; or

(3) If, pursuant to § 20:06:36:21, an insurer or health organization challenges an adjusted RBC report that indicates the event in subdivision (1) of this section, the notice by the director to the insurer or health organization that the director has, after a hearing, rejected the insurer's challenge.

Source: 23 SDR 228, effective July 3, 1997; 37 SDR 241, effective July 1, 2011.

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48.

20:06:36:08. Company action level event -- Filing of RBC plan. If a company action level event occurs, the insurer or health organization shall prepare and submit to the director an RBC plan which does the following:

(1) Identifies the conditions which contribute to the company action level event;

(2) Contains proposals of corrective actions which the insurer health organization intends to take and which would be expected to result in the elimination of the company action level event;

(3) Provide projections of the insurer's or health organization's financial results in the current year and at least the four succeeding years, both in the absence and presence of proposed corrective actions, including projections of statutory operating income, net income, capital, and surplus. The projections for both new and renewal business must include separate projections for each major line of business and separately identify each significant income, expense, and benefit component;

(4) Identifies the key assumptions affecting the insurer's or health organization's projections and the sensitivity of the projections to the assumptions; and

(5) Identifies the quality of, and problems associated with, the insurer's or health organization's business, including its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance, if any, in each case.

Source: 23 SDR 228, effective July 3, 1997.

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48.

20:06:36:09. Time for filing RBC plan. The RBC plan must be submitted within 45 days of the company action level event or, if the insurer or health organization challenges an adjusted RBC report pursuant to § 20:06:36:21, within 45 days after notice to the insurer or health organization that the director has, after a hearing, rejected the insurer's or health organization's challenge.

Source: 23 SDR 228, effective July 3, 1997.

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48.

20:06:36:10. Review of RBC plan by director. Within 60 days after the submission by an insurer or health organization of an RBC plan to the director, the director may notify the insurer whether the RBC plan shall be implemented or is, in the judgment of the director, unsatisfactory. If the director determines the RBC plan is unsatisfactory, the notice to the insurer or health organization shall set forth the reasons for the determinations and may set forth proposed revisions which will make the RBC plan satisfactory. Upon receiving notice from the director, the insurer or health organization shall prepare a revised RBC plan, which may incorporate by reference any revisions proposed by the director, and shall submit the revised RBC plan to the director within 45 days after the notice from the director or, if the insurer or health organization challenges the notice from the director under § 20:06:36:21, within 45 days after the director notifies the insurer or health organization that the director has, after a hearing, rejected the insurer's or health organization's challenge.

Source: 23 SDR 228, effective July 3, 1997.

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48.

20:06:36:11. Unsatisfactory RBC plan -- Notice of regulatory action event. If the director notifies an insurer or health organization that the insurer's or health organization's RBC plan or revised RBC plan is unsatisfactory, ~~pursuant to the requirements of § 20:06:36:08,~~ the director may, at the director's discretion and subject to the insurer's or health organization's right to a hearing under § 20:06:36:21, specify in the notice that the notice constitutes a regulatory action level event.

Source: 23 SDR 228, effective July 3, 1997.

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48

20:06:36:12. Additional filing requirements for RBC plan. Each domestic insurer or domestic health organization that files an RBC plan or revised RBC plan with the director shall file a copy of the RBC plan or revised RBC plan with the insurance director in any state in which the insurer is authorized to do business under the following circumstance:

(1) The state has an RBC provision for confidentiality substantially similar to ~~§ 20:06:36:21~~ §§ 20:06:36:22 to 20:06:36.22.02, inclusive; and

(2) If the insurance director of that state has requested the insurer or health organization in writing for the filing, the insurer or health organization shall file a copy of the RBC plan or revised RBC plan in that state by the later of 15 days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with that state or the date on which the RBC plan or revised RBC plan is filed under §§ 20:06:36:09 and 20:06:36:10.

Source: 23 SDR 228, effective July 3, 1997.

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48.

20:06:36:13. Regulatory action level event. A regulatory action level event, for any insurer or health organization, is any of the following:

(1) The filing of an RBC report by the insurer or health organization which indicates that the insurer's or health organization's total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC;

(2) The notice by the director to an insurer or health organization of an adjusted RBC report that indicates the event in subdivision (1) of this section, and the insurer or health organization does not challenge the adjusted RBC report under § 20:06:36:21;

(3) If, pursuant to § 20:06:36:21, the insurer or health organization challenges an adjusted RBC report that indicates the event in subdivision (1) of this section, the notice by the director to the insurer or health organization that the director has, after a hearing, rejected the insurer's or health organization's challenge;

(4) The failure of the insurer or health organization to file an RBC report by the filing date, unless the insurer or health organization has provided an explanation for the failure which is satisfactory to the director and has cured the failure within 10 days after the filing date;

(5) The failure of the insurer or health organization to submit an RBC plan to the director within the time required in §20:06:36:09;

(6) Notice by the director to the insurer or health organization that the RBC plan or revised RBC plan submitted by the insurer or health organization is, in the judgment of the director, unsatisfactory, and the notice constitutes a regulatory action level event for the insurer

or health organization, and the insurer or health organization has not challenged the determination under § 20:06:36:21;

(7) If, pursuant to § 20:06:36:21, the insurer or health organization challenges a determination by the director under subdivision (6) of this section, the notice by the director to the insurer or health organization that the director has, after a hearing, rejected the challenge;

(8) Notice by the director to the insurer or health organization, that the insurer or health organization has failed to adhere to its RBC plan or revised RBC plan, and the failure has a substantial adverse effect on the ability of the insurer or health organization to eliminate the company action level event in accordance with its RBC plan or revised RBC plan and the insurer or health organization has not challenged that determination under § 20:06:36:21; or

(9) If, pursuant to § 20:06:36:21, the insurer or health organization challenges a determination by the director under subdivision (8) of this section, the notice by the director to the insurer or health organization that the director has, after a hearing, rejected the challenge.

Source: 23 SDR 228, effective July 3, 1997.

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48.

20:06:36:14. Regulatory action level event -- Required actions by director. If a regulatory action level event occurs, the director shall do the following:

(1) Require the insurer or health organization to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(2) Perform any examination or analysis the director considers necessary of the assets, liabilities, and operations of the insurer or health organization, including a review of its RBC plan or revised RBC plan; and

(3) Subsequent to the examination or analysis, issue a corrective order specifying the corrective actions to be taken by the insurer or health organization. In determining corrective actions, the director may take into account any factors considered relevant to the insurer or health organization based on the director's examination or analysis of the assets, liabilities, and operations of the insurer or health organization, including the results of any sensitivity tests undertaken pursuant to the RBC instructions.

Source: 23 SDR 228, effective July 3, 1997.

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48.

20:06:36:15. Regulatory action level event -- Time for filing RBC plan or revised RBC plan. The RBC plan or revised RBC plan must be submitted as follows:

(1) Within 45 days after the occurrence of the regulatory action level event;

(2) If the insurer or health organization challenges an adjusted RBC report pursuant to § 20:06:36:21 and the challenge is not frivolous in the judgment of the director, within 45 days after the notice to the insurer or health organization that the director has, after a hearing, rejected the insurer's or health organization's challenge; or

(3) If the insurer or health organization challenges a revised RBC plan pursuant to § 20:06:36:21 and the challenge is not frivolous in the judgment of the director, within 45 days after the notice to the insurer or health organization that the director has, after a hearing, rejected the insurer's or health organization's challenge.

Source: 23 SDR 228, effective July 3, 1997.

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48.

20:06:36:16. Regulatory action level event -- Hiring of consultants by director. The director may retain actuaries and investment experts and other consultants necessary in the judgment of the director to review the insurer's or health organization's RBC plan or revised RBC plan; examine or analyze the assets, liabilities, and operations of the insurer or health organization; and formulate the corrective order for the insurer or health organization. The fees, costs, and expenses relating to consultants must be borne by the affected insurer or health organization or any other party as directed by the director.

Source: 23 SDR 228, effective July 3, 1997.

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48.

20:06:36:17. Authorized control level event. An authorized control level event is any of the following events:

(1) The filing of an RBC report by the insurer or health organization which indicates that the insurer's or health organization's total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC;

(2) The notice by the director to the insurer or health organization of an adjusted RBC report that indicates the event in subdivision (1) of this section, and the insurer or health organization does not challenge the adjusted RBC report under § 20:06:36:21;

(3) If, pursuant to § 20:06:36:21, the insurer or health organization challenges an adjusted RBC report that indicates the event in subdivision (1) of this section, notice by the director to the insurer or health organization that the director has, after a hearing, rejected the insurer's or health organization's challenge;

(4) The failure of the insurer or health organization to respond to a corrective order in a manner satisfactory to the director and the insurer or health organization has not challenged the corrective order under § 20:06:36:21; or

(5) If the insurer or health organization has challenged a corrective order under § 20:06:36:21 and the director has, after a hearing, rejected the challenge or modified the corrective order, the failure of the insurer or health organization to respond to the corrective order in a manner satisfactory to the director subsequent to rejection or modification by the director.

Source: 23 SDR 228, effective July 3, 1997.

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48.

20:06:36:18. Authorized control level event -- Actions of director. If an authorized control level event occurs, the director shall do the following:

(1) Take actions required under §§ 20:06:36:13 to 20:06:36:16, inclusive, for a regulatory action level event; or

(2) If the director considers it to be in the best interests of the policyholders and creditors of the insurer or health organization and of the public, take the actions necessary to cause the insurer or health organization to be placed under regulatory control under SDCL chapter 58-29B. If the director takes such actions, the authorized control level event is sufficient grounds for the director to take action under SDCL chapter 58-29B, and the director has the rights, powers, and duties regarding the insurer or health organization set forth in SDCL chapter 58-29B. If the director takes actions under this subdivision pursuant to an adjusted RBC report, the insurer or

health organization is entitled to the protections afforded to insurers or health organizations under the provisions of SDCL 58-29B-24 to 58-29B-30, inclusive.

Source: 23 SDR 228, effective July 3, 1997.

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48.

20:06:36:19. Mandatory control level event. A mandatory control level event is any of the following:

(1) The filing of an RBC report which indicates that the insurer's or health organization's total adjusted capital is less than its mandatory control level RBC;

(2) Notice by the director to the insurer or health organization of an adjusted RBC report that indicates the event in subdivision (1) of this section, and the insurer or health organization does not challenge the adjusted RBC report under § 20:06:36:21; or

(3) If, pursuant to § 20:06:36:21, the insurer or health organization challenges an adjusted RBC report that indicates the event in subdivision (1) of this section, notice by the director to the insurer or health organization that the director has, after a hearing, rejected the insurer's or health organization's challenge.

Source: 23 SDR 228, effective July 3, 1997.

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48.

20:06:36:20. Mandatory control level event -- Actions of director. If a mandatory control level event occurs for a life or health insurer or health organization, the director shall take the actions necessary to place the insurer or health organization under regulatory control under SDCL chapter 58-29B. The mandatory control level event is sufficient grounds for the director to

take action under SDCL chapter 58-29B, and the director has the rights, powers, and duties regarding the insurer or health organization set forth in SDCL chapter 58-29B. If the director takes actions pursuant to an adjusted RBC report, the insurer or health organization is entitled to the protections of SDCL 58-29B-24 to 58-29B-30, inclusive. However, the director may forego action for up to 90 days after the mandatory control level event if the director finds a reasonable expectation that the mandatory control level event may be eliminated within that period.

If a mandatory control level event occurs for a property and casualty insurer, the director shall take the actions necessary to place the insurer under regulatory control under SDCL chapter 58-29B, or, if an insurer is writing no business and is running off its existing business, may allow the insurer to continue its run-off under the supervision of the director. The mandatory control level event is sufficient grounds for the director to take action under SDCL chapter 58-29B and the director has the rights, powers, and duties regarding the insurer set forth in SDCL chapter 58-29B. If the director takes actions pursuant to an adjusted RBC report, the insurer is entitled to the protections of provisions SDCL 58-29B-24 to 58-29B-30, inclusive. However, the director may forego action for up to 90 days after the mandatory control level event if the director finds a reasonable expectation that the mandatory control level event may be eliminated within that period.

Source: 23 SDR 228, effective July 3, 1997.

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48.

20:06:36:21. Hearings. An insurer or health organization may challenge any determination or action by the director by requesting the director for a confidential division

hearing within five days after notice to an insurer or health organization by the director for one of the following reasons:

(1) Notice of an adjusted RBC report:

(2) Notice that the insurer's or health organization's RBC plan or revised RBC plan is unsatisfactory and the notice constitutes a regulatory action level event;

(3) Notice that the insurer or health organization has failed to adhere to its RBC plan or revised RBC plan and that the failure has a substantial adverse effect on the ability of the insurer or health organization to eliminate the company action level event in accordance with its RBC plan or revised RBC plan; or

(4) Notice of a corrective order.

Upon receipt of the insurer's or health organization's request for a hearing, the director shall set a date for the hearing which is at least 10 but not more than 30 days after the date of the insurer's or health organization's request.

Source: 23 SDR 228, effective July 3, 1997.

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48.

20:06:36:22. Confidentiality of RBC reports. All RBC reports, to the extent that information in them is not required to be set forth in a publicly available annual statement schedule, and RBC plans, including the results or report of any examination or analysis of an insurer or health organization performed pursuant to § 20:06:36:14 and any corrective order issued by the director pursuant to examination or analysis, for any domestic or foreign insurer, or any domestic or foreign health organization, which are filed with the director are confidential. This information may not be made public and is not subject to subpoena other than by the

director. The director may make this information public only for the purpose of enforcement actions pursuant to this chapter or any other provision of SDCL Title 58.

Neither the director nor any person who receives documents, materials, or other information while acting under the authority of the director is permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to this section.

20:06:36:22.01. Confidentiality of RBC reports—Sharing and receiving of information by director. In order to assist in the performance of the director's duties, the director:

(1) May share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to this section, with other state, federal, and international regulatory agencies, with the NAIC and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, or other information; and

(2) May receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from the NAIC and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

Source:

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48.

20:06:36:22.02 Confidentiality of RBC reports--Waiver. No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information occurs as a result of disclosure to the director or a result of sharing as authorized under §§ 20:06:36:22 or 20:06:36:22.01.

Source:

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48.

20:06:36:23. Assertions regarding RBC reports prohibited. Except as otherwise required by this chapter, any person engaged in any manner in the insurance business may not make, either directly or indirectly, an assertion, representation, or statement known to the public in any manner, including radio, television, and any printed form, regarding the RBC level of any insurer or health organization or regarding any component derived in the calculation of the RBC level of any insurer or health organization. Such an action is considered misleading.

If an insurer or health organization is able to prove to the director that a materially false statement comparing the insurer's or health organization's total adjusted capital to any of its RBC levels or an inappropriate comparison of any other amount to the insurer's or health organization's RBC levels has been published in a written publication, the insurer or health organization may publish an announcement in a written publication for the sole purpose of rebutting the materially false statement or inappropriate comparison.

Source: 23 SDR 228, effective July 3, 1997.

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48.

20:06:36:24. Use of RBC reports in ratemaking and premium setting prohibited. The RBC instructions, RBC reports, adjusted RBC reports, RBC plans, and revised RBC plans may be used by the director only for monitoring the solvency of insurers or health organizations and the need for possible corrective action and may not be used for ratemaking, or considered or introduced as evidence in any rate proceeding, or used to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance which an insurer, health organization, or any affiliate is authorized to write.

Source: 23 SDR 228, effective July 3, 1997.

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48.

20:06:36:25. Exemption. The director may exempt from the application of this chapter any domestic property and casualty insurer which meets the following requirements:

(1) Writes direct business only in this state;

(2) Writes direct annual premiums of $2,000,000 or less; and

(3) Assumes no reinsurance in excess of five percent of direct premiums written.

The director may exempt from the application of this chapter any domestic health organization which meets the following requirements:

(1) Writes direct business only in this state;

(2) Assumes no resinsurance in excess of five percent of direct premiums written; and

(3) Writes direct annual premiums for comprehensive medical business of $2,000,000 or less; or

(4) Is a limited health service organization that covers less than 2,000 lives.

Source: 23 SDR 228, effective July 3, 1997.

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48.

20:06:36:26. Foreign insurers and health organizations -- Filing of RBC reports and plans. At the written request of the director, any foreign insurer or foreign health organization shall submit to the director an RBC report as of the end of the calendar year just ended by the later of the date an RBC report would be required to be filed by a domestic insurer or domestic health organization under this chapter or 15 days after the request is received by the foreign insurer or foreign health organization.

At the written request of the director, any foreign insurer or foreign health organization shall promptly submit to the director a copy of any RBC plan that is filed with the insurance director of another state.

Source: 23 SDR 228, effective July 3, 1997.

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48.

20:06:36:27. Foreign insurers and health organizations -- Filing of RBC plans after certain events. If a company action level event, regulatory action level event, or authorized control level event occurs for any foreign insurer or foreign health organization as determined under the RBC statute applicable in the state of domicile of the insurer or health organization or, if no RBC statute is in force in that state, under the provisions of this chapter and the insurance

director of the state of domicile of the foreign insurer or foreign health organization fails to require the foreign insurer or foreign health organization to file an RBC plan in the manner specified under that state's RBC statute or, if no RBC statute is in force in that state, under §§ 20:06:36:07 to 20:06:36:12, inclusive, of this chapter, the foreign insurer or foreign health organization shall file an RBC plan with the director. The failure of the foreign insurer or foreign health organization to file an RBC plan with the director is grounds to order the insurer or health organization to cease and desist from writing new insurance business in this state.

Source: 23 SDR 228, effective July 3, 1997.

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48.

20:06:36:28. Foreign insurers and health organizations -- Mandatory control level event. If a mandatory control level event occurs for any foreign insurer or foreign health organization and no domiciliary receiver has been appointed for the foreign insurer or foreign health organization under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign insurer or foreign health organization, the director may apply to the circuit court of Hughes County, as permitted under SDCL chapter 58-29B, for the liquidation of property of foreign insurers or foreign health organizations found in this state. The occurrence of the mandatory control level event is adequate grounds for the application.

Source: 23 SDR 228, effective July 3, 1997.

General Authority: SDCL 58-4-48.

Law Implemented: SDCL 58-4-48.

20:06:39:61. Annual open enrollment period. For benefit years beginning on or after January 1, 2015, the annual open enrollment period for the individual market outside the individual market Exchange begins ~~October 15~~ November 15 and extends through ~~December 7 of the preceding calendar year~~ February 15.

~~Coverage is effective as of the first day of the following benefit year for a qualified individual who selects a plan selection during the annual open enrollment period.~~

Source:39 SDR 203, effective June 10, 2013.

General Authority: SDCL 58-17-87.

Law Implemented: SDCL 58-17-87.

20:06:39:71. Special enrollment triggers. After December 31, 2013, a health insurance issuer offering health insurance coverage in the individual market outside the Exchange must allow for an individual or dependent to enroll or change from one plan to another as a result of the following qualifying events:

(1) The death of the covered individual;

(2) The termination of individual's employer coverage other than by reason of gross misconduct, or reduction of hours of the covered employee's spouse;

(3) The divorce or legal separation;

(4) Individual becoming entitled to benefits under XVII of the Social Security Act;

(5) Dependent child ceasing to be dependent child;

(6) A proceeding in a case under Title 11, United States Code, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered individual retired at any time;

(7) An individual gains a dependent or becomes a dependent through marriage, birth, adoption, or placement for adoption~~;~~,and

~~(8) An individual, who was not previously a citizen, national, or lawfully present individual gains such status; and~~

~~(9)~~ (8) A qualified individual or enrollee gains access to nongrandfathered health plan as a result of a permanent move.

A health insurance issuer in the individual market must provide, with respect to individuals enrolled in non-calendar year, a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014.

This section does not apply to grandfathered plans.

Source: 39 SDR 203, effective June 10, 2013.

General Authority: SDCL 58-17-87.

Law Implemented: SDCL 58-17-87.

CHAPTER 20:06:40

EMPLOYER PLANS

Section

20:06:40:01 Waiting periods, affiliation periods, and applications relating to breaks in coverage. Repealed January 1, 2014.

20:06:40:01.01 Waiting periods and affiliation periods relating to breaks in coverage. Effective January 1, 2014.

20:06:40:02 Short-term, limited duration policies.

20:06:40:03 Certificates required upon losing coverage. Repealed January 1, 2014.

20:06:40:03.01 Certificates required upon losing coverage. Effective January 1, 2014.

20:06:40:04 Standards for determinations on length of preexisting waiting periods.

20:06:40:05 Special enrollment periods for marriage, birth, and adoption.

20:06:40:05.01 Special enrollment periods for loss of other coverage.

20:06:40:06 to 20:06:40:12 Repealed.

20:06:40:13 Public health plan defined.

20:06:40:14 and 20:06:40:15 Repealed.

20:06:40:16 Notice describing plan's special enrollment required.

20:06:40:17 Group health plans to offer breast reconstruction options after covered mastectomy.

20:06:40:17.01 Written notification regarding coverage of reconstructive surgery after a mastectomy required.

20:06:40:17.02 Prohibited practices.

20:06:40:17.03 Not a termination of collective bargaining agreement.

20:06:40:17.04 Applicability.

20:06:40:18 Claims experience defined.

20:06:40:19 to 20:06:40:22 Repealed.

20:06:40:23 Medically necessary leave of absence defined.

20:06:40:24 Dependent coverage.

20:06:40:25 Continued application in case of changed coverage.

20:06:40:27 Effective date.

20:06:40:28 Creditable coverage -- Children's Health Insurance Program.

20:06:40:29 Definitions.

20:06:40:30 Group rating based on health factors.

20:06:40:31 No group-based discrimination based on genetic information.

20:06:40:32 Limitation on requesting or requiring genetic testing.

20:06:40:33 Exceptions to requiring genetic testing.

20:06:40:34 Research exception.

20:06:40:35 Prohibitions on collection of genetic information for underwriting purposes.

20:06:40:36 Medical appropriateness.

20:06:40:37 Collection of genetic information prior to or in connection with enrollment.

20:06:40:38 Incidental collection exception.

20:06:40:39 General exception for certain small group health plans.

20:06:40:40 Applicability to excepted benefits.

20:06:40:41 Effective date.

20:06:40:42 ~~Definitions~~ Repealed.

20:06:40:43 ~~Parity requirements with respect to aggregate lifetime and annual dollar limits~~ Repealed.

20:06:40:44 ~~Plan with no limit or limits on less than one-third of all medical or surgical benefits~~ Repealed.

20:06:40:45 ~~Plan with a limit on at least two-thirds of all medical or surgical benefits~~ Repealed.

20:06:40:46 ~~Determining one-third and two-thirds of all medical or surgical benefits~~ Repealed.

20:06:40:47 ~~Plan not described in sections 20:06:40:44 or 20:06:40:45 of this chapter~~ Repealed.

20:06:40:48 ~~Parity requirements with respect to financial requirements and treatment limitations -- Clarification of classification of benefits~~ Repealed.

20:06:40:49 ~~Parity requirements with respect to financial requirements and treatment limitations -- Clarification of type of financial requirement or treatment limitation~~ Repealed.

20:06:40:50 ~~Parity requirements with respect to financial requirements and treatment limitations -- Clarification of level of a type of financial requirement or treatment limitation~~ Repealed.

20:06:40:51 ~~Parity requirements with respect to financial requirements and treatment limitations -- Clarification of coverage unit~~ Repealed.

20:06:40:52 ~~General parity requirement~~ Repealed.

20:06:40:53 ~~Classifications of benefits used for applying rules~~ Repealed.

20:06:40:54 ~~Application to out-of-network providers~~ Repealed.

20:06:40:55 ~~Financial requirements and quantitative treatment limitations -- Determining substantially all~~ Repealed.

20:06:40:56 ~~Financial requirements and quantitative treatment limitations -- Determining predominant~~ Repealed.

20:06:40:57 ~~Financial requirements and quantitative treatment limitations -- Determining portion based on plan payments~~ Repealed.

20:06:40:58 ~~Financial requirements and quantitative treatment limitations -- Determining clarifications for certain threshold requirements~~ Repealed.

20:06:40:59 ~~Application to different coverage units~~ Repealed.

20:06:40:60 ~~Special rule for multi-tiered prescription drug benefits~~ Repealed.

20:06:40:61 ~~No separate cumulative financial requirements or cumulative quantitative treatment limitations~~ Repealed.

20:06:40:62 ~~Nonquantitative treatment limitations~~ Repealed.

20:06:40:63 ~~Illustrative list of nonquantitative treatment limitations~~ Repealed.

20:06:40:64 ~~Exemptions~~ Repealed.

20:06:40:65 ~~Availability of plan information -- Criteria for medical necessity determinations~~ Repealed.

20:06:40:66 ~~Availability of plan information -- Reasons for denial~~ Repealed.

20:06:40:67 ~~Applicability -- Group health plans~~ Repealed.

20:06:40:68 ~~Applicability -- Health insurance issuers~~ Repealed.

20:06:40:69 ~~Scope~~ Repealed.

20:06:40:70 ~~Small employer exemption~~ Repealed.

20:06:40:71 ~~Determining employer size~~ Repealed.

20:06:40:72 ~~Sale of nonparity health insurance coverage~~ Repealed.

20:06:40:73 ~~Special effective date for certain collective-bargained plans~~ Repealed.

20:06:40:74 ~~Establishment of sub-classifications for determining parity for outpatient benefits~~ Repealed.

20:06:40:75 Definitions.

20:06:40:76 Guaranteed issue.

20:06:40:77 Disclosure requirements.

20:06:40:78 Guaranteed availability of coverage in the group market.

20:06:40:79 Denial of coverage.

20:06:40:80 Special enrollment period effective dates.

20:06:40:81 Special enrollment triggers.

20:06:40:82 Nonrenew or discontinuance of coverage.

20:06:40:83 Discontinuing a particular product.

20:06:40:84 Discontinuing all coverage.

20:06:40:85 Exception for uniform modification of coverage.

20:06:40:86 Preexisting condition exclusion and waiting period prohibited.

20:06:40:87 Clinical trial.

20:06:40:88 Full-time equivalents treated as full-time employees.

20:06:40:89 Applicability

Appendix A Example of Certificate of Prior Group Health Plan Coverage, repealed, 39 SDR 203, effective June 10, 2013.

Appendix B Notice of Research Exception.

20:06:40:42. Definitions. ~~Unless otherwise provided, the following terms are defined for purposes of §§ 20:06:40:42 to 20:06:40:74, inclusive:~~

~~(1) "Aggregate lifetime dollar limit," a dollar limitation on the total amount of specified benefits that may be paid under a group health plan, or health insurance coverage offered in connection with such a plan, for any coverage unit;~~

~~(2) "Annual dollar limit," a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a group health plan, or health insurance coverage offered in connection with such a plan, for any coverage unit;~~

~~(3) "Cumulative financial requirements," financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums. However, the term does not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements;~~

~~(4) "Cumulative quantitative treatment limitations," treatment limitations that determine whether or to what extent benefits are provided based on accumulated amounts, such as annual or lifetime day or visit limits;~~

~~(5) "Financial requirements," include deductibles, co-payments, coinsurance or out-of-pocket maximums. However, the term does not include aggregate lifetime or annual dollar limits;~~

~~(6) "Medical or surgical benefits," benefits for medical or surgical services, as defined under the terms of the plan, or health insurance coverage, but does not include mental health or substance use disorder benefits. Any condition defined by the plan as being or as not being a medical or surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice. For example, the International Classification of Diseases, 9th Revision, Clinical Modification (ICD) or State guidelines;~~

~~(7) "Mental health benefits," benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law. Any condition defined by the plan as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice. For example, the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM), the ICD, or State guidelines;~~

~~(8) "Substance use disorder benefits," benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law. Any disorder defined by the plan as being or as not being a substance use disorder~~

~~must be defined to be consistent with generally recognized independent standards of current medical practice. For example, the DSM, the ICD, or state guidelines;~~

~~(9) "Treatment limitations," include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically, such as 50 outpatient visits per year, and nonquantitative treatment limitations, which otherwise limit the scope or duration for treatment under a plan. See § 20:06:40:63 for an illustrative list of nonquantitative treatment limitations.~~ Repealed.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-18-79.~~

~~**Law Implemented:** SDCL 58-18-79, 58-18-79(1), 58-18-79(15), 58-18-80.~~

20:06:40:43. Parity requirements with respect to aggregate lifetime and annual dollar limits. ~~A group health plan, or health insurance coverage offered by an issuer in connection with a group health plan, that provides medical or surgical benefits and mental health or substance use disorder benefits must comply with § 20:06:40:44, 20:06:40:45, or 20:06:40:47. However, §§ 20:06:40:42 to 20:06:40:74, inclusive, does not apply if a plan, or health insurance coverage, satisfies the requirements of §§ 20:06:40:70 and 20:06:40:71, relating to exemptions for small employers and for increased costs.~~ Repealed.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-18-79, 58-18-79(15).~~

~~**Law Implemented:** SDCL 58-18-79, 58-18-80.~~

20:06:40:44. Plan with no limit or limits on less than one-third of all medical or surgical benefits. ~~If a plan, or health insurance coverage, does not include an aggregate lifetime or annual dollar limit on any medical or surgical benefits, it may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.~~ Repealed.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-18-79, 58-18-79(15).~~

~~**Law Implemented:** SDCL 58-18-79, 58-18-80.~~

20:06:40:45. Plan with a limit on at least two-thirds of all medical or surgical benefits. ~~If a plan, or health insurance coverage, includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical or surgical benefits, it must either:~~

~~(1) Apply the aggregate lifetime or annual dollar limit both to the medical or surgical benefits to which the limit would otherwise apply and to mental health or substance use disorder benefits in a manner that does not distinguish between the medical or surgical benefits and mental health or substance use disorder benefits; or~~

~~(2) Not include an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is less than the aggregate lifetime or annual dollar limit, respectively, on medical or surgical benefits. For cumulative limits other than aggregate lifetime or annual dollar limits, see § 20:06:41:61, prohibiting separately accumulating cumulative financial requirements or cumulative quantitative treatment limitations.~~Repealed.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-18-79, 58-18-79(15).~~

~~**Law Implemented:** SDCL 58-18-79, 58-18-80.~~

20:06:40:46. Determining one-third and two-thirds of all medical or surgical benefits. ~~For purposes of §§ 20:06:40:43 to 20:06:40:47, inclusive, the determination of whether the portion of medical or surgical benefits subject to an aggregate lifetime or annual dollar limit represents one-third or two-thirds of all medical or surgical benefits, is based on the dollar amount of all plan payments for medical or surgical benefits expected to be paid under the plan for the plan year, or for the portion of the plan year after a change in plan benefits that affects the applicability of the aggregate lifetime or annual dollar limits.~~Repealed.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-18-79, 58-18-79(15).~~

~~**Law Implemented:** SDCL 58-18-79, 58-18-80.~~

20:06:40:47. Plan not described in sections 20:06:40:44 or 20:06:40:45 of this chapter. ~~A group health plan, or health insurance coverage, that is not described in § 20:06:40:44 or 20:06:40:45 with respect to aggregate lifetime or annual dollar limits on medical or surgical benefits must either:~~

~~(1) Impose no aggregate lifetime or annual dollar limit, as appropriate, on mental health or substance use disorder benefits; or~~

~~(2) Impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no less than an average limit calculated for medical or surgical benefits in the following manner. The average limit is calculated by taking into account the weighted average of the aggregate lifetime or annual dollar limits, as appropriate, that are applicable to the categories of medical or surgical benefits. Limits based on delivery systems, such as inpatient, outpatient treatment or normal treatment of common, low-cost conditions such as treatment of normal births, do not constitute categories for purposes of subdivision 20:06:40:47(2). In~~

~~addition, for purposes of determining weighted averages, any benefits that are not within a category that is subject to a separately-designated dollar limit under the plan are taken into account as a single separate category by using an estimate of the upper limit on the dollar amount that a plan may reasonably expect to incur with respect to such benefits, taking into account any other applicable restrictions under the plan.~~

~~For purposes of this section, the weighting applicable to any category of medical or surgical benefits is determined in the manner set forth in § 20:06:40:46 for determining one-third or two-thirds of all medical or surgical benefits.~~ Repealed.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-18-79, 58-18-79(15).~~

~~**Law Implemented:** SDCL 58-18-79, 58-18-80.~~

20:06:40:48. Parity requirements with respect to financial requirements and treatment limitations -- Clarification of classification of benefits. ~~When reference is made in §§ 20:06:40:48 to 20:06:40:64, inclusive, to a classification of benefits, the term "classification" means a classification as described in §§ 20:06:40:53 and 20:06:40:54.~~ Repealed.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-18-79, 58-18-79(1), 58-18-79(15).~~

~~**Law Implemented:** SDCL 58-18-79, 58-18-80.~~

20:06:40:49. Parity requirements with respect to financial requirements and treatment limitations -- Clarification of type of financial requirement or treatment limitation. ~~When reference is made in §§ 20:06:40:48 to 20:06:40:64, inclusive, to a type of financial requirement or treatment limitations, the reference to type means its nature. Different~~

~~types of financial requirements include deductibles, co-payments, coinsurance, and out-of-pocket maximums. Different types of quantitative treatment limitations include annual, episode, and lifetime day and visit limits. See § 20:06:40:63 for an illustrative list of nonquantitative treatment limitations.~~ Repealed.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-18-79, 58-18-79(1), 58-18-79(15).~~

~~**Law Implemented:** SDCL 58-18-79, 58-18-80.~~

20:06:40:50. Parity requirements with respect to financial requirements and treatment limitations -- Clarification of level of a type of financial requirement or treatment limitation. ~~When reference is made in §§ 20:06:40:48 to 20:06:40:64, inclusive, to a level of a type of financial requirement or treatment limitation, level refers to the magnitude of the type of financial requirement of treatment limitation. For example, different levels of coinsurance include 20 percent and 30 percent; different levels of a co-payment include $15 and $20; different levels of a deductible include $250 and $500; and different levels of an episode limit include 21 inpatient days per episode and 30 inpatient days per episode.~~ Repealed.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-18-79.~~

~~**Law Implemented:** SDCL 58-18-79(1), 58-18-79(15), 58-18-80.~~

20:06:40:51. Parity requirements with respect to financial requirements and treatment limitations -- Clarification of coverage unit. ~~When reference is made in §§ 20:06:40:42 to 20:06:40:74, inclusive, to a coverage unit, coverage unit refers to the way in which a plan, or health insurance coverage, groups individuals for purposes of determining~~

~~benefits, or premiums or contributions. For example, different coverage units include self-only, family, and employee-plus-spouse.~~Repealed.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-18-79.~~

~~**Law Implemented:** SDCL 58-18-79(1), 58-18-79(15), 58-18-80.~~

20:06:40:52. General parity requirement. ~~A group health plan, or health insurance coverage offered by an issuer in connection with a group health plan, that provides both medical or surgical benefits and mental health or substance use disorder benefits may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all, medical or surgical benefits, in the same classification. Whether a financial requirement or treatment limitation is a predominant financial requirement or treatment limitation that applies to substantially all medical surgical benefits in a classification is determined separately for each type of financial requirement or treatment limitation. The application of the rules found in §§ 20:06:40:52 to 20:06:40:54, inclusive, to financial requirements and quantitative treatment limitation is addressed in §§ 20:06:40:55 to 20:06:40:61, inclusive; the application of the rules of §§ 20:06:40:52 to 20:06:40:54, inclusive, to nonquantitative treatment limitations is addressed in §§ 20:06:40:63 and 20:06:40:64.~~ Repealed.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-18-79, 58-18-79(15).~~

~~**Law Implemented:** SDCL 58-18-79, 58-18-80.~~

20:06:40:53. Classifications of benefits used for applying rules. ~~If a plan, or health insurance coverage, provides mental health or substance use disorder benefits in any classification of benefits described in §§ 20:06:40:53 and 20:06:40:54, mental health or substance use disorder benefits must be provided in every classification in which medical or surgical benefits are provided. In determining the classification in which a particular benefit belongs, a plan, or health insurance issuer, must apply the same standards to medical or surgical benefits and to mental health or substance use disorder benefits. To the extent that a plan, or health insurance coverage, provides benefits in a classification and imposes any separate financial requirement or treatment limitation, or separate level of a financial requirement or treatment limitation, for benefits in the classification, the rules of §§ 20:06:40:48 to 20:06:40:64, inclusive, apply separately with respect to that classification for all financial requirement or treatment limitations.~~

~~The following classifications of benefits are the only classifications used in applying the rules of §§ 20:06:40:48 to 20:06:40:64, inclusive.~~

~~(1) "Inpatient, in-network," benefits furnished on an inpatient basis and with a network of providers established or recognized under a plan or health insurance coverage;~~

~~(2) "Inpatient, out-of-network," benefits furnished on an inpatient basis and outside any network of providers established or recognized under a plan or health insurance coverage. This classification includes inpatient benefits under a plan, or health insurance coverage, that has no network or providers;~~

~~(3) "Outpatient, in-network," benefits furnished on an outpatient basis and within a network of providers established or recognized under a plan or health insurance coverage;~~

~~(4) "Outpatient, out-of-network," benefits furnished on an outpatient basis and outside any network of providers established or recognized under a plan or health insurance coverage. This classification includes outpatient benefits under a plan, or health insurance coverage, that has no network of providers;~~

~~(5) "Emergency care," benefits for emergency care;~~

~~(6) "Prescription drugs," benefits for prescription drugs. See special rules for multi-tiered prescription drug benefits in § 20:06:40:60.~~ Repealed.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-18-79, 58-18-79(15).~~

~~**Law Implemented:** SDCL 58-18-79, 58-18-80.~~

20:06:40:54. Application to out-of-network providers. ~~A plan, or health insurance coverage, that provides mental health or substance use disorder benefits in any classification of benefits must provide mental health or substance use disorder benefits in every classification in which medical or surgical benefits are provided, including out-of-network classifications.~~ Repealed.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-18-79, 58-18-79(15).~~

~~**Law Implemented:** SDCL 58-18-79, 58-18-80.~~

20:06:40:55. Financial requirements and quantitative treatment limitations -- Determining substantially all. ~~For purposes of §§ 20:06:40:48 to 20:06:40:67, inclusive, a type of financial requirement or quantitative treatment limitation is considered to apply to substantially all medical or surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical or surgical benefits in that classification. Benefits expressed as subject~~

~~to a zero level of a type of financial requirement are treated as benefits not subject to that type of financial requirement, and benefits expressed as subject to a quantitative treatment limitation that is unlimited are treated as benefits not subject to that type of quantitative treatment limitation. If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of all medical or surgical benefits in a classification, then that type cannot be applied to mental health or substance use disorder benefits in that classification.~~ Repealed.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-18-79, 58-18-79(15).~~

~~**Law Implemented:** SDCL 58-18-79, 58-18-80.~~

20:06:40:56. Financial requirements and quantitative treatment limitations -- Determining predominant. ~~If a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical or surgical benefits in a classification as determined under § 20:06:40:58, the level of the financial requirement or quantitative treatment limitation that is considered the predominant level of that type in a classification of benefits is the level that applies to more than one-half of medical or surgical benefits in that classification subject to the financial requirement or quantitative treatment limitation.~~

~~If, with respect to a type of financial requirement or quantitative treatment limitations that applies to a least two-thirds of all medical or surgical benefits in a classification, there is no single level that applies to more than one-half of medical or surgical benefits in the classification subject to the financial requirement or quantitative treatment limitation, the plan, or health insurance issuer, may combine levels until the combination of levels applies to more than one-half of medical or surgical benefits subject to the financial requirement or quantitative treatment limitation in the classification. The least restrictive level within the combination is considered the~~

~~predominate level of that type in the classification. A plan may combine the most restrictive levels first, with each less restrictive level added to the combination until the combination applies to more than one-half of the benefits subject to the financial requirement or treatment limitations.~~ Repealed.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-18-79, 58-18-79(15).~~

~~**Law Implemented:** SDCL 58-18-79, 58-18-80.~~

20:06:40:57. Financial requirements and quantitative treatment limitations -- Determining portion based on plan payments. ~~For purposes of §§ 20:06:40:48 to 20:06:40:64, inclusive, the determination of the portion of medical or surgical benefits in a classification of benefits subject to a financial requirement or quantitative treatment limitation, or subject to any level of a financial requirement or quantitative treatment limitation, is based on the dollar amount of all plan payments for medical or surgical benefits in the classification expected to be paid under the plan for the plan year or for the portion of the plan year after a change in plan benefits that affects the applicability of the financial requirement or quantitative treatment limitation.~~ Repealed.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-18-79, 58-18-79(15).~~

~~**Law Implemented:** SDCL 58-18-79, 58-18-80.~~

20:06:40:58. Financial requirements and quantitative treatment limitations -- Determining clarifications for certain threshold requirements. ~~For any deductible, the dollar amount of plan payments includes all plan payments with respect to claims that would be subject to the deductible if it had not been satisfied. For any out-of-pocket maximum, the dollar amount~~

~~of plan payments includes all plan payments associated with out-of-pocket payments that are taken into account towards the out-of-pocket maximum as well as all plan payments associated with out-of-pocket payments that would have been made towards the out-of-pocket maximum if it had not been satisfied.~~ Repealed.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-18-79, 58-18-79(15).~~

~~**Law Implemented:** SDCL 58-18-79, 58-18-80.~~

20:06:40:59. Application to different coverage units. ~~If a plan, or health insurance coverage, applies different levels of a financial requirement or quantitative treatment limitation to different coverage units in a classification of medical or surgical benefits, the predominant level that applies to substantially all medical or surgical benefits in the classification is determined separately for each coverage unit.~~ Repealed.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-18-79, 58-18-79(15).~~

~~**Law Implemented:** SDCL 58-18-79, 58-18-80.~~

20:06:40:60. Special rule for multi-tiered prescription drug benefits. ~~If a plan, or health insurance coverage, applies different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors determined in accordance with § 20:06:40:62, relating to requirements for nonquantitative treatment limitations, and without regard to whether a drug is generally prescribed with respect to medical or surgical benefits or with respect to mental health or substance use disorder benefits, the plan, or health insurance coverage, satisfies the parity requirements of §§ 20:06:40:48 to 20:06:40:64, inclusive, with~~

~~respect to prescription drug benefits. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up.~~ Repealed.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-18-79, 58-18-79(15).~~

~~**Law Implemented:** SDCL 58-18-79, 58-18-80.~~

20:06:40:61. No separate cumulative financial requirements or cumulative quantitative treatment limitations. ~~A group health plan, or health insurance coverage, offered in connection with a group health plan, may not apply any cumulative financial requirement or cumulative quantitative treatment limitation for mental health or substance use disorder benefits in a classification that accumulates separately from any established for medical or surgical benefits in the same classification.~~ Repealed.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-18-79, 58-18-79(15).~~

~~**Law Implemented:** SDCL 58-18-79, 58-18-80.~~

20:06:40:62. Nonquantitative treatment limitations. ~~A group health plan, or health insurance coverage, may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan, or health insurance coverage, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to classification, except to the extent that recognized clinically appropriate standards of care may permit a difference.~~ Repealed.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-18-79, 58-18-79(15).~~

~~**Law Implemented:** SDCL 58-18-79, 58-18-80.~~

20:06:40:63. Illustrative list of nonquantitative treatment limitations. ~~Nonquantitative treatment limitations include:~~

~~(1) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;~~

~~(2) Formulary design for prescription drugs;~~

~~(3) Standards for provider admission to participate in a network, including reimbursement rates;~~

~~(4) Plan methods for determining usual, customary, and reasonable charges;~~

~~(5) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective, also known as fail-first policies or step therapy protocols; and~~

~~(6) Exclusions based on failure to complete a course of treatment.~~ Repealed.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-18-79, 58-18-79(15).~~

~~**Law Implemented:** SDCL 58-18-79, 58-18-80.~~

20:06:40:64. Exemptions. ~~The rules in §§ 20:06:40:48 to 20:06:40:64, inclusive, do not apply if a group health plan, or health insurance coverage, satisfies the requirements of §§ 20:06:40:70 and 20:06:40:71.~~ Repealed.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-18-79, 58-18-79(15).~~

~~**Law Implemented:** SDCL 58-18-79, 58-18-80.~~

20:06:40:65. Availability of plan information -- Criteria for medical necessity determinations. ~~The criteria for medical necessity determinations made under a group health plan with respect to mental health or substance use disorder benefits, or health insurance coverage offered in connection with the plan with respect to such benefits, must be made available by the plan administrator, or health insurance issuer offering such coverage, to any current or potential participant, beneficiary, or contracting provider upon request.~~ Repealed.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-18-79, 58-18-79(15).~~

~~**Law Implemented:** SDCL 58-18-79, 58-18-80.~~

20:06:40:66. Availability of plan information -- Reasons for denial. ~~The reason for any denial under a group health plan, or health insurance coverage, of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary must be made available by the plan administrator, or the health insurance issuer offering such coverage, to the participant or beneficiary, in accordance with this section.~~

~~A group health plan, or health insurance coverage, must provide the reason for the claim denial in a form and manner consistent with the requirements for group health plans found in 29 CFR 2560.503-1 as of January 1, 2011.~~ Repealed.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-18-79, 58-18-79(15).~~

~~**Law Implemented:** SDCL 58-18-79, 58-18-80.~~

20:06:40:67. Applicability -- Group health plans. ~~The requirements of §§ 20:06:40:42 to 20:06:40:74, inclusive, apply to a group health plan offering, medical or surgical benefits, and mental health or substance use disorder benefits. If, under an arrangement or arrangements to provide health care benefits by an employer or employee organization including for this purpose a joint board of trustees of a multiemployer trust affiliated with one or more multiemployer plans, any participant or beneficiary can simultaneously receive coverage for medical or surgical benefits and coverage for mental health or substance use disorder benefits, then the requirements of §§ 20:06:40:42 to 20:06:40:74, inclusive, apply separately with respect to each combination of medical or surgical benefits and of mental health or substance use disorder benefits, that any participant or beneficiary can simultaneously receive from that employer's or employee organization's arrangement or arrangements to provide health care benefits, and all such combinations are considered for purposes of §§ 20:06:40:42 to 20:06:40:74, inclusive, to be a single group plan.~~ Repealed.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-18-79, 58-18-79(15).~~

~~**Law Implemented:** SDCL 58-18-79, 58-18-80.~~

20:06:40:68. Applicability -- Health insurance issuers. ~~The requirements of §§ 20:06:40:42 to 20:06:40:74, inclusive, apply to a health insurance issuer offering health insurance coverage for mental health or substance use disorder benefits in connection with a group health plan subject to § 20:60:40:67.~~ Repealed.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-18-79, 58-18-79(15).~~

~~**Law Implemented:** SDCL 58-18-79, 58-18-80.~~

20:06:40:69. Scope. ~~Sections 20:06:40:42 to 20:06:40:74, inclusive, do not:~~

~~(1) Require a group health plan, or health insurance issuer offering coverage in connection with a group health plan, to provide any mental health benefits or substance use disorder benefits, and the provision of benefits by a plan, or health insurance coverage, for one or more mental health conditions or substance use disorders does not require the plan, or health insurance coverage, under §§ 20:06:40:42 to 20:06:40:70, inclusive, to provide benefits for any other mental health condition or substance use disorder; or~~

~~(2) Affect the terms and conditions relating to the amount, duration, or scope of mental health or substance use disorder benefits under the plan, or health insurance coverage, except as specifically provided in §§ 20:06:40:43 to 20:06:40:64, inclusive.~~ Repealed.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-18-79, 58-18-79(15).~~

~~**Law Implemented:** SDCL 58-18-79, 58-18-80.~~

20:06:40:70. Small employer exemption. ~~The requirements of §§ 20:06:40:42 to 20:06:40:74, inclusive, do not apply to a group health plan, or health insurance issuer offering coverage in connection with a group health plan, for a plan year of a small employer. For purposes of §§ 20:06:40:70 and 20:06:40:71, the term "small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed at least a single individual, but not more than 50 employees on business days during the preceding calendar year and who employs at least a single individual on the first day of the plan year.~~ Repealed.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-18-79, 58-18-79(15).~~

~~**Law Implemented:** SDCL 58-18-79, 58-18-80.~~

20:06:40:71. Determining employer size. ~~For purposes of § 20:06:40:70:~~

~~(1) All persons treated as a single employer under subsections (b), (c), (m), and (o) of the Internal Revenue Code of 1986, codified at 26 U.S.C. 414, are treated as one employer;~~

~~(2) If an employer was not in existence throughout the preceding calendar year, whether it is a small employer is determined based on the average number of employees the employer reasonably expects to employ on business days during the current calendar year; and~~

~~(3) Any reference to an employer for purposes of the small employer exemption includes a reference to a predecessor of the employer.~~ Repealed.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-18-79, 58-18-79(15).~~

~~**Law Implemented:** SDCL 58-18-79, 58-18-80.~~

20:06:40:72. Sale of nonparity health insurance coverage. ~~A health insurance issuer may not sell a policy, certificate, or contract of insurance that fails to comply with §§ 20:06:40:43 to 20:06:40:64, inclusive, except to a plan for a year for which the plan is exempt from requirements of §§ 20:06:40:42 to 20:06:40:74, inclusive, because the plan meets requirements under §§ 20:06:40:70 and 20:06:40:71.~~ Repealed.

Source: 37 SDR 215, effective May 31, 2011.

General Authority: SDCL 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-18-79, 58-18-80.

20:06:40:73. Special effective date for certain collectively-bargained plans. ~~For a group health plan maintained pursuant to one or more collective bargaining agreements ratified before October 3, 2008, the requirements of §§ 20:06:40:42 to 20:06:40:74, inclusive, do not apply to~~

~~the plan, or health insurance coverage offered in connection with the plan, for plan years beginning before the later of either:~~

~~(1) The date on which the last of the collective bargaining agreements relating to the plan terminates, determined without regard to any extension agreed to after October 3, 2008; or~~

~~(2) July 1, 2010.~~ Repealed.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-18-79, 58-18-79(15).~~

~~**Law Implemented:** SDCL 58-18-79, 58-18-80.~~

20:06:40:74. Establishment of sub-classifications for determining parity for outpatient benefits. ~~For purposes of applying the financial requirements and treatment limitations found in §§ 20:06:40:42 to 20:06:40:74, inclusive, a group health plan, or health insurance coverage offered by an issuer in connection with a group health plan, may divide its benefits furnished on an outpatient basis into two sub-classifications:~~

~~(1) Office visits; and~~

~~(2) All other outpatient items and services.~~

~~After the sub-classifications are established, a group health plan, or health insurance coverage offered by an issuer in connection with a group health plan, may not impose any financial requirement or treatment limitation on mental health or substance use disorder benefits in any sub-classification that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical or surgical benefits in the sub-classification using the methodology set forth in §§ 20:06:40:42 to 20:06:40:74, inclusive.~~

~~Other than as permitted under this section, and except as permitted under § 20:06:40:60, sub-classifications are not permitted when applying the financial requirements and treatment~~

~~limitations found in §§ 20:06:40:42 to 20:06:40:74, inclusive. Accordingly, separate sub-classifications for generalists and specialists are not permitted.~~ Repealed.

Source: 37 SDR 215, effective May 31, 2011; 39 SDR 219, effective June 26, 2013.

~~**General Authority:** SDCL 58-18-79, 58-18-79(15).~~

~~**Law Implemented:** SDCL 58-18-79, 58-18-80.~~

~~**References: International Classification of Disease**, 9th Revision, Clinical Modification (ICD-9-CM), 2010. Copies may be obtained from Optum, Inc., P.O. Box 27116, Salt Lake City, Utah 84127-0116; $99.95.~~

~~**DSM-IV-TR--Diagnostic and Statistical Manual of Mental Disorders**, Fourth Edition, Text Revision, published by the American Psychiatric Association. Copies may be obtained from Optum, Inc., P.O. Box 27116, Salt Lake City, Utah 84127-0116; $99.95.~~

CHAPTER 20:06:43

ANNUITY MORTALITY TABLES

Section

20:06:43:01 Definitions.

20:06:43:02 Individual annuity or pure endowment contracts.

20:06:43:02:01 Application of the 2012 IAR Mortality Table

20:06:43:03 Group annuity or pure endowment contracts.

20:06:43:04 Application of the 1994 GAR Table.

Appendix A 2012 IAM Period Table, Female

Appendix B 2012 IAM Period Table, Male

Appendix C Projection Scale G2, Female

Appendix D Projection Scale G2, Male

20:06:43:01. Definitions. Terms used in this chapter mean:

(1) "1983 Table 'a'," a mortality table developed by the Society of Actuaries Committee to Recommend a New Mortality Basis for Individual Annuity Valuation and adopted as a recognized mortality table for annuities by the National Association of Insurance Commissioners;

(2) "1983 GAM Table," a mortality table developed by the Society of Actuaries Committee on Annuities and adopted as a recognized mortality table for annuities by the National Association of Insurance Commissioners;

(3) "1994 GAR Table," a mortality table developed by the Society of Actuaries Group Annuity Valuation Table Task Force and adopted as a recognized mortality table for annuities by the National Association of Insurance Commissioners;

(4) "Annuity 2000 Mortality Table," a mortality table developed by the Society of Actuaries Committee on Life Insurance Research and adopted as a recognized mortality table by the National Association of Insurance Commissioners~~.~~;

(5) “Period Table,” a table of mortality rates applicable to a given calendar year (the period);

(6) “Generational Mortality Table,” a mortality table containing a set of mortality rates that decrease for a given age from one year to the next based on a combination of a Period Table and a projection scale containing rates of mortality improvement;

(7) “2012 IAR Table,” a Generational Mortality Table developed by the Society of Actuaries Committee on Life Insurance Research and containing rates, q_x^{2012+n}, derived from a combination of the 2012 IAM Period Table and Projection Scale G2, using the methodology stated in § 20:06:43:02:01;

(8) “2012 Individual Annuity Mortality Period Life (2012 IAM Period) Table,” the Period Table containing loaded mortality rates for calendar year 2012. This table contains rates, q_x^{2012}, developed by the Society of Actuaries Committee on Life Insurance Research and is shown in Appendices A-B;

(9) “Projection Scale G2 (Scale G2),” a table of annual rates, $G2_x$, of mortality improvement by age for projecting future mortality rates beyond calendar year 2012 developed by the Society of Actuaries Committee on Life Insurance Research and is shown in Appendices C-D.

Source: 26 SDR 55, effective October 24, 1999.

General Authority:SDCL 58-26-66, 58-26-67, 58-26-69.

Law Implemented:SDCL 58-26-66, 58-26-67, 58-26-69.

References: For 1983 Table "a", **1982 Proceedings of the NAIC**, Volume II, page 454, National Association of Insurance Commissioners. Copies of the entire volume may be obtained from the National Association of Insurance Commissioners, Attention Publications Department, 120 West Twelfth Street, Suite 1100, Kansas City, MO 64105, Telephone Number (816) 374-7259. Cost: Free for members; $180 for nonmembers. Copies of individual pages may be

obtained from the National Association of Insurance Commissioners, Attention Research Library, 120 West Twelfth Street, Suite 1100, Kansas City, MO 64105, Telephone Number (816) 374-7175. Cost: Free for members; $10 flat fee plus 30 cents per page certain for nonmembers (with a higher charge for pages uncertain). For 1983 GAM Table, **1984 Proceedings of the NAIC**, Volume I, pages 414-415, National Association of Insurance Commissioners. Copies of the entire volume may be obtained from the National Association of Insurance Commissioners, Attention Publications Department, 120 West Twelfth Street, Suite 1100, Kansas City, MO 64105, Telephone Number (816) 374-7259. Cost: Free for members; $180 for nonmembers. Copies of individual pages may be obtained from the National Association of Insurance Commissioners, Attention Research Library, 120 West Twelfth Street, Suite 1100, Kansas City, MO 64105, Telephone Number (816) 374-7175. Cost: Free for members; $10 flat fee plus 30 cents per page certain for nonmembers (with a higher charge for pages uncertain). For 1994 GAR Table, **Transactions of the Society of Actuaries**, Volume XLVII, 1995, pages 865-919, Society of Actuaries. Copies may be obtained from the Society of Actuaries, Attention Publications Department, 475 North Martingale Road, Suite 800, Schaumburg, IL 60173-2226, Telephone Number (847) 706-3526. Cost: $55 per book. For copies of tables, first 40 pages, $10 for members and $20 for nonmembers; each additional page, 25 cents for members and 50 cents for nonmembers. For Annuity 2000 Mortality Table, **Transactions of the Society of Actuaries**, Volume XLVII, 1995, pages 211-249, Society of Actuaries. Copies may be obtained from Society of Actuaries, Attention Publications Department, 475 North Martingale Road, Suite 800, Schaumburg, IL 60173-2226, Telephone Number (847) 706-3526. Cost: $55 per book. For copies of tables, first 40 pages, $10 for members and $20 for nonmembers; each additional page, 25 cents for members and 50 cents for nonmembers.

20:06:43:02. Individual annuity or pure endowment contracts.

(1) Except as provided in ~~subdivisions 2 and 3~~ subdivision 2 of this section, the 1983 Table "a" and the Annuity 2000 Mortality Table are recognized and approved as individual annuity mortality tables for valuation and, at the option of the company, either of these tables may be used for purposes of determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after July 1, 1978.

(2) Except as provided in subdivision 3 of this section, the Annuity 2000 Mortality Table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after January 1, 2001.

(3) Except as provided in subdivision 4 of this section, the 2012 IAR Mortality Table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after January 1, 2015.

~~(3)~~(4) The 1983 Table "a" without projection is to be used for determining the minimum standards of valuation for an individual annuity or pure endowment contract issued on or after January 1, 2001, solely when the contract is based on life contingencies and is issued to fund periodic benefits arising from:

(a) Settlements of various forms of claims pertaining to court settlements or out of court settlements from tort actions;

(b) Settlements involving similar actions such as worker’s compensation claims; or

(c) Settlements of long term disability claims where a temporary or life annuity has been used in lieu of continuing disability payments.

Source: 26 SDR 55, effective October 24, 1999.

General Authority: SDCL 58-26-66, 58-26-67.

Law Implemented: SDCL 58-26-66, 58-26-67.

References: For 1983 Table "a", **1982 Proceedings of the NAIC**, Volume II, page 454, National Association of Insurance Commissioners. Copies of the entire volume may be obtained from the National Association of Insurance Commissioners, Attention Publications Department, 120 West Twelfth Street, Suite 1100, Kansas City, MO 64105, Telephone Number (816) 374-7259. Cost: Free for members; $180 for nonmembers. Copies of individual pages may be obtained from the National Association of Insurance Commissioners, Attention Research Library, 120 West Twelfth Street, Suite 1100, Kansas City, MO 64105, Telephone Number (816) 374-7175. Cost: Free for members; $10 flat fee plus 30 cents per page certain for nonmembers (with a higher charge for pages uncertain). For Annuity 2000 Mortality Table, **Transactions of the Society of Actuaries**, Volume XLVII, 1995, pages 211-249, Society of Actuaries. Copies may be obtained from the Society of Actuaries, Attention Publications Department, 475 North Martingale Road, Suite 800, Schaumburg, IL 60173-2226, Telephone Number (847) 706-3526. Cost: $55 per book. For copies of tables, first 40 pages, $10 for members and $20 for nonmembers; each additional page, 25 cents for members and 50 cents for nonmembers.

20:06:43:02:01. Application of the 2012 IAR Mortality Table. In using the 2012 IAR Mortality Table, the mortality rate for a person age x in year (2012 + n) is calculated as follows:

$$q_x^{2012+n} = q_x^{2012}(1 - G2_x)^n$$

The resulting q_x^{2012+n} shall be rounded to three decimal places per 1,000, e.g., 0.741 deaths per 1,000. Also, the rounding shall occur according to the formula above, starting at the 2012 period table rate.

General Authority: SDCL 58-26-69.

Law Implemented: SDCL 58-26-69.

DEPARTMENT OF LABOR AND REGULATION

DIVISION OF INSURANCE

2012 IAM PERIOD TABLE
FEMALE, AGE NEAREST BIRTHDAY

Chapter 20:06:43

APPENDIX A

SEE: § 20:06:43:01

Source:

Appendix A.

AGE	$1000 \cdot q_x^{2012}$	AGE	$1000 \cdot q_x^{2012}$	AGE	$1000 \cdot q_x^{2012}$	AGE	$1000 \cdot q_x^{2012}$
0	**1.621**	30	**0.300**	60	**3.460**	90	**88.377**
1	**0.405**	31	**0.321**	61	**3.916**	91	**97.491**
2	**0.259**	32	**0.338**	62	**4.409**	92	**107.269**
3	**0.179**	33	**0.351**	63	**4.933**	93	**118.201**
4	**0.137**	34	**0.365**	64	**5.507**	94	**130.969**
5	**0.125**	35	**0.381**	65	**6.146**	95	**146.449**
6	**0.117**	36	**0.402**	66	**6.551**	96	**163.908**
7	**0.110**	37	**0.429**	67	**7.039**	97	**179.695**
8	**0.095**	38	**0.463**	68	**7.628**	98	**196.151**
9	**0.088**	39	**0.504**	69	**8.311**	99	**213.150**
10	**0.085**	40	**0.552**	70	**9.074**	100	**230.722**
11	**0.086**	41	**0.600**	71	**9.910**	101	**251.505**
12	**0.094**	42	**0.650**	72	**10.827**	102	**273.007**
13	**0.108**	43	**0.697**	73	**11.839**	103	**295.086**
14	**0.131**	44	**0.740**	74	**12.974**	104	**317.591**
15	**0.156**	45	**0.780**	75	**14.282**	105	**340.362**
16	**0.179**	46	**0.825**	76	**15.799**	106	**362.371**
17	**0.198**	47	**0.885**	77	**17.550**	107	**384.113**
18	**0.211**	48	**0.964**	78	**19.582**	108	**400.000**
19	**0.221**	49	**1.051**	79	**21.970**	109	**400.000**
20	**0.228**	50	**1.161**	80	**24.821**	110	**400.000**
21	**0.234**	51	**1.308**	81	**28.351**	111	**400.000**
22	**0.240**	52	**1.460**	82	**32.509**	112	**400.000**
23	**0.245**	53	**1.613**	83	**37.329**	113	**400.000**
24	**0.247**	54	**1.774**	84	**42.830**	114	**400.000**
25	**0.250**	55	**1.950**	85	**48.997**	115	**400.000**
26	**0.256**	56	**2.154**	86	**55.774**	116	**400.000**
27	**0.261**	57	**2.399**	87	**63.140**	117	**400.000**
28	**0.270**	58	**2.700**	88	**71.066**	118	**400.000**
29	**0.281**	59	**3.054**	89	**79.502**	119	**400.000**
						120	**1000.000**

DEPARTMENT OF LABOR AND REGULATION

DIVISION OF INSURANCE

2012 IAM PERIOD TABLE
MALE, AGE NEAREST BIRTHDAY

Chapter 20:06:43

APPENDIX B

SEE: § 20:06:43:01

Source:

Appendix B.

AGE	$1000 \cdot q_x^{2012}$	AGE	$1000 \cdot q_x^{2012}$	AGE	$1000 \cdot q_x^{2012}$	AGE	$1000 \cdot q_x^{2012}$
0	**1.605**	30	**0.741**	60	**5.069**	90	**109.993**
1	**0.401**	31	**0.751**	61	**5.614**	91	**123.119**
2	**0.275**	32	**0.754**	62	**6.169**	92	**137.168**
3	**0.229**	33	**0.756**	63	**6.759**	93	**152.171**
4	**0.174**	34	**0.756**	64	**7.398**	94	**168.194**
5	**0.168**	35	**0.756**	65	**8.106**	95	**185.260**
6	**0.165**	36	**0.756**	66	**8.548**	96	**197.322**
7	**0.159**	37	**0.756**	67	**9.076**	97	**214.751**
8	**0.143**	38	**0.756**	68	**9.708**	98	**232.507**
9	**0.129**	39	**0.800**	69	**10.463**	99	**250.397**
10	**0.113**	40	**0.859**	70	**11.357**	100	**268.607**
11	**0.111**	41	**0.926**	71	**12.418**	101	**290.016**
12	**0.132**	42	**0.999**	72	**13.675**	102	**311.849**
13	**0.169**	43	**1.069**	73	**15.150**	103	**333.962**
14	**0.213**	44	**1.142**	74	**16.860**	104	**356.207**
15	**0.254**	45	**1.219**	75	**18.815**	105	**380.000**
16	**0.293**	46	**1.318**	76	**21.031**	106	**400.000**
17	**0.328**	47	**1.454**	77	**23.540**	107	**400.000**
18	**0.359**	48	**1.627**	78	**26.375**	108	**400.000**
19	**0.387**	49	**1.829**	79	**29.572**	109	**400.000**
20	**0.414**	50	**2.057**	80	**33.234**	110	**400.000**
21	**0.443**	51	**2.302**	81	**37.533**	111	**400.000**
22	**0.473**	52	**2.545**	82	**42.261**	112	**400.000**
23	**0.513**	53	**2.779**	83	**47.441**	113	**400.000**
24	**0.554**	54	**3.011**	84	**53.233**	114	**400.000**
25	**0.602**	55	**3.254**	85	**59.855**	115	**400.000**
26	**0.655**	56	**3.529**	86	**67.514**	116	**400.000**
27	**0.688**	57	**3.845**	87	**76.340**	117	**400.000**
28	**0.710**	58	**4.213**	88	**86.388**	118	**400.000**
29	**0.727**	59	**4.631**	89	**97.634**	119	**400.000**
						120	**1000.000**

DEPARTMENT OF LABOR AND REGULATION

DIVISION OF INSURANCE

PROJECTION SCALE G2
FEMALE, AGE NEAREST BIRTHDAY

Chapter 20:06:43

APPENDIX C

SEE: § 20:06:43:01

Source:

Appendix C.

AGE	$G2_x$	AGE	$G2_x$	AGE	$G2_x$	AGE	$G2_x$
0	**0.010**	30	**0.010**	60	**0.013**	90	**0.006**
1	**0.010**	31	**0.010**	61	**0.013**	91	**0.006**
2	**0.010**	32	**0.010**	62	**0.013**	92	**0.005**
3	**0.010**	33	**0.010**	63	**0.013**	93	**0.005**
4	**0.010**	34	**0.010**	64	**0.013**	94	**0.004**
5	**0.010**	35	**0.010**	65	**0.013**	95	**0.004**
6	**0.010**	36	**0.010**	66	**0.013**	96	**0.004**
7	**0.010**	37	**0.010**	67	**0.013**	97	**0.003**
8	**0.010**	38	**0.010**	68	**0.013**	98	**0.003**
9	**0.010**	39	**0.010**	69	**0.013**	99	**0.002**
10	**0.010**	40	**0.010**	70	**0.013**	100	**0.002**
11	**0.010**	41	**0.010**	71	**0.013**	101	**0.002**
12	**0.010**	42	**0.010**	72	**0.013**	102	**0.001**
13	**0.010**	43	**0.010**	73	**0.013**	103	**0.001**
14	**0.010**	44	**0.010**	74	**0.013**	104	**0.000**
15	**0.010**	45	**0.010**	75	**0.013**	105	**0.000**
16	**0.010**	46	**0.010**	76	**0.013**	106	**0.000**
17	**0.010**	47	**0.010**	77	**0.013**	107	**0.000**
18	**0.010**	48	**0.010**	78	**0.013**	108	**0.000**
19	**0.010**	49	**0.010**	79	**0.013**	109	**0.000**
20	**0.010**	50	**0.010**	80	**0.013**	110	**0.000**
21	**0.010**	51	**0.010**	81	**0.012**	111	**0.000**
22	**0.010**	52	**0.011**	82	**0.012**	112	**0.000**
23	**0.010**	53	**0.011**	83	**0.011**	113	**0.000**
24	**0.010**	54	**0.011**	84	**0.010**	114	**0.000**
25	**0.010**	55	**0.012**	85	**0.010**	115	**0.000**
26	**0.010**	56	**0.012**	86	**0.009**	116	**0.000**
27	**0.010**	57	**0.012**	87	**0.008**	117	**0.000**
28	**0.010**	58	**0.012**	88	**0.007**	118	**0.000**
29	**0.010**	59	**0.013**	89	**0.007**	119	**0.000**
						120	**0.000**

DEPARTMENT OF LABOR AND REGULATION

DIVISION OF INSURANCE

PROJECTION SCALE G2
MALE, AGE NEAREST BIRTHDAY

Chapter 20:06:43

APPENDIX D

SEE: § 20:06:43:01

Source:

Appendix D.

AGE	$G2_x$	AGE	$G2_x$	AGE	$G2_x$	AGE	$G2_x$
0	**0.010**	30	**0.010**	60	**0.015**	90	**0.007**
1	**0.010**	31	**0.010**	61	**0.015**	91	**0.007**
2	**0.010**	32	**0.010**	62	**0.015**	92	**0.006**
3	**0.010**	33	**0.010**	63	**0.015**	93	**0.005**
4	**0.010**	34	**0.010**	64	**0.015**	94	**0.005**
5	**0.010**	35	**0.010**	65	**0.015**	95	**0.004**
6	**0.010**	36	**0.010**	66	**0.015**	96	**0.004**
7	**0.010**	37	**0.010**	67	**0.015**	97	**0.003**
8	**0.010**	38	**0.010**	68	**0.015**	98	**0.003**
9	**0.010**	39	**0.010**	69	**0.015**	99	**0.002**
10	**0.010**	40	**0.010**	70	**0.015**	100	**0.002**
11	**0.010**	41	**0.010**	71	**0.015**	101	**0.002**
12	**0.010**	42	**0.010**	72	**0.015**	102	**0.001**
13	**0.010**	43	**0.010**	73	**0.015**	103	**0.001**
14	**0.010**	44	**0.010**	74	**0.015**	104	**0.000**
15	**0.010**	45	**0.010**	75	**0.015**	105	**0.000**
16	**0.010**	46	**0.010**	76	**0.015**	106	**0.000**
17	**0.010**	47	**0.010**	77	**0.015**	107	**0.000**
18	**0.010**	48	**0.010**	78	**0.015**	108	**0.000**
19	**0.010**	49	**0.010**	79	**0.015**	109	**0.000**
20	**0.010**	50	**0.010**	80	**0.015**	110	**0.000**
21	**0.010**	51	**0.011**	81	**0.014**	111	**0.000**
22	**0.010**	52	**0.011**	82	**0.013**	112	**0.000**
23	**0.010**	53	**0.012**	83	**0.013**	113	**0.000**
24	**0.010**	54	**0.012**	84	**0.012**	114	**0.000**
25	**0.010**	55	**0.013**	85	**0.011**	115	**0.000**
26	**0.010**	56	**0.013**	86	**0.010**	116	**0.000**
27	**0.010**	57	**0.014**	87	**0.009**	117	**0.000**
28	**0.010**	58	**0.014**	88	**0.009**	118	**0.000**
29	**0.010**	59	**0.015**	89	**0.008**	119	**0.000**
						120	**0.000**

20:06:55:49. Annual open enrollment period. For benefit years after December 31, 2014, inside the Exchange all issuers must provide for an annual open enrollment period for the individual market inside the Exchange that begins ~~October 15~~ November 15 and extends through ~~December 7of the preceding calendar year~~ February 15.

~~Coverage must be effective as of the first day of the following benefit year for a qualified individual who selects a qualified health plan during the annual open enrollment period.~~

Source:39 SDR 203, adopted June 10, 2013, effective January 1, 2014.

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:55:50. Changing qualified health plans. A health insurance issuer must allow a qualified individual or enrollee in an Exchange to enroll in or change from one qualified health plan to another as a result of the following triggering events:

~~(1) A qualified individual or dependent loses minimum essential coverage except for in the case of nonpayment of premium;~~

(1) The qualified individual or his or her dependent either:

(i) Loses minimum essential coverage except for in the case of nonpayment of premium. The date of the loss of coverage is the last day the consumer would have coverage under their previous plan or coverage;

(ii) Is enrolled in any non-calendar year health insurance policy that will expire in 2014 as described in 45 C.F.R §147.104(b)(2) (December 3, 2014), even if the qualified individual or their dependent has the option to renew the expiring non-calendar year individual health

insurance policy. The date of the loss of coverage is the date in 2014 of the expiration of the non-calendar year policy;

(iii) Loses pregnancy-related coverage described under section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX) (December 3, 2014)). The date of the loss of coverage is the last day the consumer would have pregnancy-related coverage; or

(iv) Loses medically needy coverage as described under section 1902(a)(10)(C) of the Social Security Act only once per calendar year. The date of the loss of coverage is the last day the consumer would have medically needy coverage;

(2) A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption;

(3) An individual, who was not previously a citizen, national, or lawfully present individual gains such status;

(4) A qualified individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the health insurance issuer. In such cases, the health insurance issuer may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;

(5) An enrollee adequately demonstrates to the director that the qualified health plan in which the individual is enrolled substantially violated a material provision of its contract in relation to the individual;

(6) A qualified individual or enrollee gains access to new qualified health plans as a result of a permanent move;

(7) A qualified individual or enrollee meets other exceptional circumstances as the director may provide; ~~and~~

(8) An Indian, as defined by section 4 of the Indian Health Care Improvement Act, Pub. L. No. 94-437 (1976), as amended, may enroll in a qualified health plan or change from one qualified health plan to another one time per month and is not subject to any qualifying event~~.~~ ; and

(9) An individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The Exchange must permit an individual whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for the individual's employer's upcoming plan year to access this special enrollment period prior to the end of the individual's coverage through such eligible employer sponsored plan. A qualified individual or the individual's dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for advance payments of the premium tax credit based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR 1.36B-2(c)(3) (December 3, 2014), including as a result of the individual's employer

discontinuing or changing available coverage within the next 60 days, provided that such individual is allowed to terminate existing coverage.

A qualified individual or enrollee has 60 days from the date of a triggering event to select a qualified health plan. A qualified individual or the individual's dependent who is described in subsection 1 of this section has 60 days before and after the loss of coverage to select a qualified health plan. A qualified individual or the individual's dependent who is described in subsection 9 of this section has 60 days before and after the loss of eligibility for qualifying coverage in an eligible employer-sponsored plan to select a qualified health plan.

Source:39 SDR 203, adopted June 10, 2013, effective January 1, 2014.

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:55:50.02. Special enrollment period effective dates. After December 31, 2013, a health insurance issuer must provide special enrollment periods consistent with this section inside the Exchange, during which qualified individuals and enrollees may enroll in nongrandfathered health plans or change enrollment from one plan to another. Once a qualified individual is determined eligible for a special enrollment period, the health insurance issuer must ensure that the qualified individual's date of coverage is:

(1) Between the first and the fifteenth day of any month, the plan must ensure a coverage effective date of the first day of the following month;

(2) Between the sixteenth and the last day of any month, the plan must ensure a coverage effective date of the first day of the second following month;

(3) In the case of birth, adoption or placement for adoption, or placement in foster care, the plan must ensure that coverage is effective on the date of birth, adoption, ~~or~~ placement for adoption, or placement in foster care. If the Exchange permits the qualified individual or enrollee to elect a coverage effective date of the first day of the month following the date of birth, adoption, placement for adoption, or placement in foster care, the Exchange must ensure coverage is effective on such date elected by the qualified individual or enrollee;

(4) In the case of marriage, or in the case where a qualified individual loses minimum essential coverage, the plan must ensure coverage is effective on the first day of the ~~following month~~ month following plan selection;

(5) In the case of a qualified individual or enrollee eligible for a special enrollment period as described §§ 20:06:55:50(4), 20:06:55:50(5), or 20:06:55:50(7) the plan must ensure coverage is effective on an appropriate date based on the circumstances of the special enrollment period; and

(6) In a case where an individual loses coverage as described in subdivision 20:06:55:50(1) if the plan selection is made before or on the day of the loss of coverage, the Exchange must ensure that the coverage effective date is on the first day of the month following the loss of coverage. If the plan selection is made after the loss of coverage, the Exchange must ensure that coverage is effective in accordance with subsection (1) and (2) of this section or on the first day of the month following plan selection in accordance with subsection (3) and (4) of this section.

Source:39 SDR 203, adopted June 10, 2013, effective January 1, 2014.

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

CHAPTER 20:06:56

MINIMUM BENEFIT STANDARDS

Section

20:06:56:01 Definitions.

20:06:56:02 Covering essential health benefits.

20:06:56:03 Essential health benefit packages.

20:06:56:04 Substantially equal benefits.

20:06:56:05 Substituted benefits.

20:06:56:06 Pediatric dental.

20:06:56:07 Prohibited benefits.

20:06:56:08 Prescription drug benefits.

20:06:56:09 Prohibited discriminatory benefit design.

20:06:56:10 Actuarial value calculator.

20:06:56:11 Levels of coverage.

20:06:56:12 Accreditation.

20:06:56:13 Accreditation timeline.

20:06:56:14 Provider credentialing.

20:06:56:15 Annual limitation on cost sharing.

20:06:56:16 Annual limitation on deductibles for plans in the small group market.

20:06:56:17 Network plan cost sharing.

20:06:56:18 Increase annual dollar limits in multiples of 50.

20:06:56:19 Catastrophic plan.

20:06:56:20 Applicability.

20:06:56:21 Exception for uniform modification of coverage.

20:06:56:08. Prescription drug benefits. A health plan does not provide essential health benefits unless it covers at least the greater of:

(1) One drug in every United States Pharmacopeia (USP) category and class; or

(2) The same number of prescription drugs in each category and class as the essential health benefits benchmark.

The plan is required to submit its drug list to the director. A health plan does not fail to provide essential health benefits for prescription drug solely because it does not offer drugs for services prohibited under SDCL 58-17-147. A health plan providing essential health benefits as defined in § 20:06:56:03 must have procedures in place that allow an enrollee to request clinically appropriate drugs not covered by the health plan. Such procedures must include a process for an enrollee, the enrollee's designee, or the enrollee's prescribing physician or other prescriber to request an expedited review based on exigent circumstances.

Exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug.

A health plan must make its coverage determination on an expedited review request based on exigent circumstances and notify the enrollee or the enrollee's designee and the

prescribing physician or other prescriber, as appropriate of its coverage determination no later than 24 hours after it receives the request.

A health plan that grants an exception based on exigent circumstances must provide coverage of the non-formulary drug for the duration of the exigency.

Source:39 SDR 203, effective June 10, 2013.

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

Reference: United States Pharmacopeia (USP).

20:06:56:21. Exception for uniform modification of coverage. Only at the time of coverage renewal may issuers modify the health insurance coverage for a product offered to a group health plan or an individual, as applicable, in the large group market, the individual market, and the small group market if, for coverage available in this market, other than only through one or more bona fide associations.

Modifications made uniformly and solely pursuant to applicable federal or state requirements are considered a uniform modification of coverage in the small group and individual market if:

1. The modification is made within a reasonable time period after the imposition or modification of the federal or state requirement;
2. The modification is directly related to the imposition or modification of the federal or state requirement;

3. Other types of modifications made uniformly are considered a uniform modification of coverage if the health insurance coverage for the product in the individual or small group market meets all of the following criteria:

   (i) The product is offered by the same health insurance issuer;

   (ii) The product is offered as the same product network type;

   (iii) The product continues to cover at least a majority of the same service area;

   (iv) Within the product, each plan has the same cost-sharing structure as before the modification, except for any variation in cost sharing solely related to changes in cost and utilization of medical care, or to maintain the same metal tier level described in sections 1302(d) and (e) of the Affordable Care Act (December 3, 2014); and

   (v) The product provides the same covered benefits, except for any changes in benefits that cumulatively impact the plan-adjusted index rate for any plan within the product within an allowable variation of +/- two percentage points.

The director may broaden the standards in subsection 3(iii) and (iv) of this section after consideration of the impact on the insurance-buying public.

If an issuer in the individual market is renewing non-grandfathered coverage or uniformly modifying non-grandfathered coverage the issuer must provide to each individual written notice of the renewal before the date of the first day of the next annual open enrollment period.

If an issuer in the small group market is renewing coverage or uniformly modifying coverage the issuer must provide to each plan sponsor or individual written notice of the renewal at least 60 calendar days before the date of the coverage will be renewed.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

CHAPTER 20:06:58

MENTAL HEALTH PARITY

Section

20:06:58:01 Definitions.

20:06:58:02 Parity requirements with respect to aggregate lifetime and annual dollar limits

20:06:58:03 Plan with no limit or limits on less than one-third of all medical or surgical benefits

20:06:58:04 Plan with a limit on at least two-thirds of all medical or surgical benefits.

20:06:58:05 Determining one-third and two-thirds of all medical or surgical benefits.

20:06:58:06 Plan not described in sections 20:06:40:44 or 20:06:40:45 of this chapter.

20:06:58:07 Parity requirements with respect to financial requirements and treatment limitations -- Clarification of classification of benefits.

20:06:58:08 Parity requirements with respect to financial requirements and treatment limitations -- Clarification of type of financial requirement or treatment limitation.

20:06:58:09 Parity requirements with respect to financial requirements and treatment limitations -- Clarification of level of a type of financial requirement or treatment limitation.

20:06:58:10 Parity requirements with respect to financial requirements and treatment limitations -- Clarification of coverage unit.

20:06:58:11 General parity requirement.

20:06:58:12 Classifications of benefits used for applying rules.

20:06:58:13 Application to out-of-network providers.

20:06:58:14 Financial requirements and quantitative treatment limitations -- Determining substantially all.

20:06:58:15 Financial requirements and quantitative treatment limitations -- Determining predominant.

20:06:58:16 Financial requirements and quantitative treatment limitations -- Determining portion based on plan payments.

20:06:58:17 Financial requirements and quantitative treatment limitations -- Determining clarifications for certain threshold requirements.

20:06:58:18 Application to different coverage units.

20:06:58:19 Special rule for multi-tiered prescription drug benefits.

20:06:58:20. Special rule for multiple network tiers.

20:06:58:21. Special rule for sub-classifications permitted for office visits, separate from other outpatient services.

20:06:58:22 No separate cumulative financial requirements or cumulative quantitative treatment limitations.

20:06:58:23 Nonquantitative treatment limitations.

20:06:58:24 Illustrative list of nonquantitative treatment limitations.

20:06:58:25 Exemptions.

20:06:58:26 Availability of plan information -- Criteria for medical necessity determinations.

20:06:58:27 Availability of plan information -- Reasons for denial.

20:06:58:28 Applicability and effective dates -- Group health plans.

20:06:58:29 Applicability and effective dates -- Health insurance issuers.

20:06:58:30 Scope.

20:06:58:31. Coordination with EHB requirements

20:06:58:32 Small employer exemption.

20:06:58:33 Determining employer size.

20:06:58:34. Increased cost exemption

20:06:58:35. Applicable percentage.

20:06:58:36. Determinations by actuaries.

20:06:58:37. Formula.

20:06:58:38. Six month determination.

20:06:58:39. Notification.

20:06:58:40. Participants and beneficiaries.

20:06:58:41. Use of summary of material reductions in covered services or benefits.

20:06:58:42. Delivery.

20:06:58:43. Availability of documentation.

20:06:58:44 Sale of nonparity health insurance coverage.

20:06:58:45 Special effective date for certain collective-bargained plans.

20:06:58:01. Definitions. Unless otherwise provided, terms used in this chapter mean:

(1) "Aggregate lifetime dollar limit," a dollar limitation on the total amount of specified benefits that may be paid under a group health plan, or health insurance coverage offered in connection with such a plan, for any coverage unit;

(2) "Annual dollar limit," a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a group health plan, or health insurance coverage offered in connection with such a plan, for any coverage unit;

(3) "Cumulative financial requirements," financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums. The term does not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements;

(4) "Cumulative quantitative treatment limitations," treatment limitations that determine whether or to what extent benefits are provided based on accumulated amounts, such as annual or lifetime day or visit limits;

(5) "Financial requirements," include deductibles, co-payments, coinsurance, or out-of-pocket maximums. The term does not include aggregate lifetime or annual dollar limits;

(6) "Medical or surgical benefits," benefits with respect to items or services for medical conditions or surgical procedures, as defined under the terms of the plan, or health insurance coverage and in accordance with applicable federal and state law, but does not include mental health or substance use disorder benefits. Any condition defined by the plan as being or as not being a medical or surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice;

(7) "Mental health benefits," benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable federal and state law. Any condition defined by the plan as being or as not being a mental health condition

must be defined to be consistent with generally recognized independent standards of current medical practice;

(8) "Substance use disorder benefits," benefits with respect to items or services for substance use disorders, as defined under the terms of the plan and in accordance with applicable federal and state law. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice;

(9) "Treatment limitations," include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically, such as 50 outpatient visits per year, and nonquantitative treatment limitations, which otherwise limit the scope or duration for treatment under a plan. A permanent exclusion of all benefits for a particular condition or disorder is not a treatment limitation for purposes of this definition.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-79(1), 58-18-79(15), 58-18-80.

Cross-Reference: Illustrative list of nonquantitative limitations, § 20:06:58:24.

20:06:58:02. Parity requirements with respect to aggregate lifetime and annual dollar limits. A group health plan, or health insurance coverage offered by an issuer in connection with

a group health plan, that provides medical or surgical benefits and mental health or substance use disorder benefits must comply with § 20:06:58:03, 20:06:58:04, or 20:06:58:06. However, §§ 20:06:58:01 to 20:06:58:45, inclusive, do not apply if a plan, or health insurance coverage, satisfies the requirements of § 20:06:58:32 or § 20:06:40:34, relating to exemptions for small employers and for increased costs.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:03. Plan with no limit or limits on less than one-third of all medical or surgical benefits. If a plan, or health insurance coverage, does not include an aggregate lifetime or annual dollar limit on any medical or surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical or surgical benefits, it may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:04. Plan with a limit on at least two-thirds of all medical or surgical benefits. If a plan, or health insurance coverage, includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical or surgical benefits, it must either:

(1) Apply the aggregate lifetime or annual dollar limit both to the medical or surgical benefits to which the limit would otherwise apply and to mental health or substance use disorder benefits in a manner that does not distinguish between the medical or surgical benefits and mental health or substance use disorder benefits; or

(2) Not include an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is less than the aggregate lifetime or annual dollar limit, respectively, on medical or surgical benefits.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

Cross Reference: No separate cumulative financial requirements or cumulative quantitative treatment limitations, § 20:06:58:22.

20:06:58:05. Determining one-third and two-thirds of all medical or surgical benefits. For purposes of §§ 20:06:58:01 to 20:06:58:45, inclusive, the determination of whether the portion of medical or surgical benefits subject to an aggregate lifetime or annual dollar limit represents one-third or two-thirds of all medical or surgical benefits, is based on the dollar amount of all plan payments for medical or surgical benefits expected to be paid under the plan for the plan year, or

for the portion of the plan year after a change in plan benefits that affects the applicability of the aggregate lifetime or annual dollar limits. Any reasonable method may be used to determine whether the dollar amount expected to be paid under the plan will constitute one-third or two-thirds of the dollar amount of all plan payments for medical or surgical benefits.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:06. Plan not described in sections 20:06:58:03 or 20:06:58:04 of this chapter. A group health plan, or health insurance coverage, that is not described in § 20:06:58:03 or 20:06:58:04 with respect to aggregate lifetime or annual dollar limits on medical or surgical benefits must either:

(1) Impose no aggregate lifetime or annual dollar limit, as appropriate, on mental health or substance use disorder benefits; or

(2) Impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no less than an average limit calculated for medical or surgical benefits in the following manner. The average limit is calculated by taking into account the weighted average of the aggregate lifetime or annual dollar limits, as appropriate, that are applicable to the categories of medical or surgical benefits. Limits based on delivery systems, such as inpatient, outpatient treatment or normal treatment of common, low-cost conditions such as treatment of normal births, do not constitute categories for purposes of subdivision 20:06:58:06(2). In addition, for purposes of determining weighted averages, any benefits that are not within a category that is subject to a separately-designated dollar limit under the plan are taken into

account as a single separate category by using an estimate of the upper limit on the dollar amount that a plan may reasonably expect to incur with respect to such benefits, taking into account any other applicable restrictions under the plan.

For purposes of this section, the weighting applicable to any category of medical or surgical benefits is determined in the manner set forth in § 20:06:58:05 for determining one-third or two-thirds of all medical or surgical benefits.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:07. Parity requirements with respect to financial requirements and treatment limitations -- Clarification of classification of benefits. For purposes of §§ 20:06:58:07 to 20:06:58:25, inclusive, when referring to a classification of benefits, the term "classification" means a classification as described in §§ 20:06:58:12 and 20:06:58:13.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(1), 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:08. Parity requirements with respect to financial requirements and treatment limitations -- Clarification of type of financial requirement or treatment

limitation. For purposes of §§ 20:06:58:07 to 20:06:58:25, inclusive, when referring to a type of financial requirement or treatment limitation, the type means its nature. Types of financial requirements include deductibles, co-payments, coinsurance, and out-of-pocket maximums. Types of quantitative treatment limitations include annual, episode, and lifetime day and visit limits.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(1), 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

Cross Reference: Illustrative list of nonquantitative treatment limitations, § 20:06:58:24.

20:06:58:09. Parity requirements with respect to financial requirements and treatment limitations -- Clarification of level of a type of financial requirement or treatment limitation. For purposes of §§ 20:06:58:07 to 20:06:58:25, inclusive, when referring to a level of a type of financial requirement or treatment limitation, level is the magnitude of the type of financial requirement of treatment limitation. For example, different levels of coinsurance include 20 percent and 30 percent; different levels of a co-payment include $15 and $20; different levels of a deductible include $250 and $500; and different levels of an episode limit include 21 inpatient days per episode and 30 inpatient days per episode.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79(1), 58-18-79(15), 58-18-80.

20:06:58:10. Parity requirements with respect to financial requirements and treatment limitations -- Clarification of coverage unit. For purposes of §§ 20:06:58:01 to 20:06:58:45, inclusive, a coverage unit means the way in which a plan, or health insurance coverage, groups individuals for purposes of determining benefits, premiums, or contributions. For example, different coverage units include self-only, family, and employee-plus-spouse.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79(1), 58-18-79(15), 58-18-80.

20:06:58:11. General parity requirement. A group health plan, or health insurance coverage offered by an issuer in connection with a group health plan, that provides both medical or surgical benefits and mental health or substance use disorder benefits may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all, medical or surgical benefits, in the same classification. Whether a financial requirement or treatment limitation is a predominant financial requirement or treatment limitation that applies to substantially all medical surgical benefits in a classification is determined separately for each type of financial requirement or treatment limitation. The application of the rules found in §§ 20:06:58:11 to 20:06:58:13, inclusive, to financial requirements and quantitative treatment limitation is addressed in §§ 20:06:58:14 to 20:06:58:22, inclusive; the application of the rules of §§ 20:06:58:11 to 20:06:58:13, inclusive, to nonquantitative treatment limitations is addressed in §§ 20:06:58:24 and 20:06:58:25.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:12. Classifications of benefits used for applying rules. If a plan, or health insurance coverage, provides mental health or substance use disorder benefits in any classification of benefits described in §§ 20:06:58:12 and 20:06:58:13, mental health or substance use disorder benefits must be provided in every classification in which medical or surgical benefits are provided. In determining the classification in which a particular benefit belongs, a plan, or health insurance issuer, must apply the same standards to medical or surgical benefits and to mental health or substance use disorder benefits. To the extent that a plan, or health insurance coverage, provides benefits in a classification and imposes any separate financial requirement or treatment limitation, or separate level of a financial requirement or treatment limitation, for benefits in the classification, the rules of §§ 20:06:58:07 to 20:06:58:25, inclusive, apply separately with respect to that classification for all financial requirement or treatment limitations.

The following classifications of benefits are the only classifications used in applying the rules of §§ 20:06:58:07 to 20:06:58:25, inclusive:

(1) "Inpatient, in-network," benefits furnished on an inpatient basis and within a network of providers established or recognized under a plan or health insurance coverage;

(2) "Inpatient, out-of-network," benefits furnished on an inpatient basis and outside any network of providers established or recognized under a plan or health insurance coverage. This

classification includes inpatient benefits under a plan, or health insurance coverage, that has no network or providers;

(3) "Outpatient, in-network," benefits furnished on an outpatient basis and within a network of providers established or recognized under a plan or health insurance coverage;

(4) "Outpatient, out-of-network," benefits furnished on an outpatient basis and outside any network of providers established or recognized under a plan or health insurance coverage. This classification includes outpatient benefits under a plan, or health insurance coverage, that has no network of providers;

(5) "Emergency care," benefits for emergency care;

(6) "Prescription drugs," benefits for prescription drugs.

If a plan, or health insurance coverage, provides benefits only to the extent required under the PHS Act, 29 CFR 2713 (December 3, 2014), this section is not intended to require the plan, or health insurance coverage, to provide additional mental health or substance use disorder benefits in any classification.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

Cross Reference: Special rule for multi-tiered prescription drug benefits, § 20:06:58:19.

20:06:58:13. Application to out-of-network providers. A plan, or health insurance coverage, that provides mental health or substance use disorder benefits in any classification of

benefits must provide mental health or substance use disorder benefits in every classification in which medical or surgical benefits are provided, including out-of-network classifications.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:14. Financial requirements and quantitative treatment limitations -- Determining substantially all. For purposes of §§ 20:06:58:07 to 20:06:58:25, inclusive, a type of financial requirement or quantitative treatment limitation is considered to apply to substantially all medical or surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical or surgical benefits in that classification. Benefits expressed as subject to a zero level of a type of financial requirement are treated as benefits not subject to that type of financial requirement, and benefits expressed as subject to a quantitative treatment limitation that is unlimited are treated as benefits not subject to that type of quantitative treatment limitation. If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of all medical or surgical benefits in a classification, then that type cannot be applied to mental health or substance use disorder benefits in that classification.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:15. Financial requirements and quantitative treatment limitations -- Determining predominant. If a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical or surgical benefits in a classification as determined under § 20:06:58:17, the level of the financial requirement or quantitative treatment limitation that is considered the predominant level of that type in a classification of benefits is the level that applies to more than one-half of medical or surgical benefits in that classification subject to the financial requirement or quantitative treatment limitation.

If, with respect to a type of financial requirement or quantitative treatment limitation that applies to a least two-thirds of all medical or surgical benefits in a classification, there is no single level that applies to more than one-half of medical or surgical benefits in the classification subject to the financial requirement or quantitative treatment limitation, the plan, or health insurance issuer, may combine levels until the combination of levels applies to more than one-half of medical or surgical benefits subject to the financial requirement or quantitative treatment limitation in the classification. The least restrictive level within the combination is considered the predominate level of that type in the classification. A plan may combine the most restrictive levels first, with each less restrictive level added to the combination until the combination applies to more than one-half of the benefits subject to the financial requirement or treatment limitation.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:16. Financial requirements and quantitative treatment limitations -- Determining portion based on plan payments. For purposes of §§ 20:06:58:07 to 20:06:58:25, inclusive, the determination of the portion of medical or surgical benefits in a classification of benefits subject to a financial requirement or quantitative treatment limitation, or subject to any level of a financial requirement or quantitative treatment limitation, is based on the dollar amount of all plan payments for medical or surgical benefits in the classification expected to be paid under the plan for the plan year or for the portion of the plan year after a change in plan benefits that affects the applicability of the financial requirement or quantitative treatment limitation.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:17. Financial requirements and quantitative treatment limitations -- Determining clarifications for certain threshold requirements and dollar amount of plan payments. For any deductible, the dollar amount of plan payments includes all plan payments with respect to claims that would be subject to the deductible if it had not been satisfied. For any out-of-pocket maximum, the dollar amount of plan payments includes all plan payments associated with out-of-pocket payments that are taken into account towards the out-of-pocket maximum as well as all plan payments associated with out-of-pocket payments that would have been made towards the out-of-pocket maximum if it had not been satisfied.

Any reasonable method may be used to determine the dollar amount expected to be paid under a plan for medical or surgical benefits subject to a financial requirement or quantitative

treatment limitation or subject to any level of a financial requirement or quantitative treatment limitation.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:18. Application to different coverage units. If a plan, or health insurance coverage, applies different levels of a financial requirement or quantitative treatment limitation to different coverage units in a classification of medical or surgical benefits, the predominant level that applies to substantially all medical or surgical benefits in the classification is determined separately for each coverage unit.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:19. Special rule for multi-tiered prescription drug benefits. If a plan, or health insurance coverage, applies different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors determined in accordance with § 20:06:58:23, relating to requirements for nonquantitative treatment limitations, and without regard to whether a drug is generally prescribed with respect to medical or surgical benefits or with respect to mental health or substance use disorder benefits, the plan, or health insurance coverage, satisfies the parity requirements of §§ 20:06:58:07 to 20:06:58:25, inclusive, with

respect to prescription drug benefits. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:20. Special rule for multiple network tiers. If a plan, or health insurance coverage, provides benefits through multiple tiers of in-network providers, such as an in-network tier of preferred providers with more generous cost-sharing to participants than a separate in-network tier of participating providers, the plan may divide its benefits furnished on an in-network basis into sub-classifications that reflect network tiers, if the tiering is based on reasonable factors determined in accordance with § 20:06:58:23 and without regard to whether a provider provides services with respect to medical or surgical benefits or mental health or substance use disorder benefits. After the sub-classifications are established, the plan or issuer may not impose any financial requirement or treatment limitation on mental health or substance use disorder benefits in any sub-classification that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical or surgical benefits in the sub-classification using the methodology set forth in §§ 20:06:58:14 to 20:06:58:17, inclusive.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:21. Special rule for sub-classifications permitted for office visits, separate from other outpatient services. For purposes of applying the financial requirement and treatment limitation rules of §§ 20:06:58:07 to 20:06:58:25, inclusive, a plan or issuer may divide its benefits furnished on an outpatient basis into the two sub-classifications described in this section. After the sub-classifications are established, the plan or issuer may not impose any financial requirement or quantitative treatment limitation on mental health or substance use disorder benefits in any sub-classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical or surgical benefits in the sub-classification using the methodology set forth in paragraph §§ 20:06:58:14 to 20:06:58:17, inclusive. Sub-classifications other than these special rules, such as separate sub-classifications for generalists and specialists, are not permitted. The two sub-classifications permitted under this section are:

(1) Office visits, such as physician visits, and

(2) All other outpatient items and services, such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:22. No separate cumulative financial requirements or cumulative quantitative treatment limitations. A group health plan, or health insurance coverage, offered in connection with a group health plan, may not apply any cumulative financial requirement or cumulative quantitative treatment limitation for mental health or substance use disorder benefits in a classification that accumulates separately from any established for medical or surgical benefits in the same classification.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:23. Nonquantitative treatment limitations. A group health plan, or health insurance coverage, may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan, or health insurance coverage, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical or surgical benefits in the classification.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:24. Illustrative list of nonquantitative treatment limitations. Nonquantitative treatment limitations include:

(1) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;

(2) Formulary design for prescription drugs;

(3) Standards for provider admission to participate in a network, including reimbursement rates;

(4) Plan methods for determining usual, customary, and reasonable charges;

(5) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective, also known as fail-first policies or step therapy protocols;

(6) Exclusions based on failure to complete a course of treatment;

(7) For plans with multiple network tiers, such as preferred providers and participating providers, network tier design; and

(8) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:25. Exemptions. The rules in §§ 20:06:58:07 to 20:06:58:25, inclusive, do not apply if a group health plan, or health insurance coverage, satisfies the requirements of §§ 20:06:58:32 and 20:06:58:33 or §§ 20:06:58:34 to 20:06:58:43, inclusive.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:26. Availability of plan information -- Criteria for medical necessity determinations. The criteria for medical necessity determinations made under a group health plan with respect to mental health or substance use disorder benefits, or health insurance coverage offered in connection with the plan with respect to such benefits, must be made available by the plan administrator, or health insurance issuer offering such coverage, to any current or potential participant, beneficiary, or contracting provider upon request.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:27. Availability of plan information -- Reasons for denial. The reason for any denial under a group health plan, or health insurance coverage offered in connection with such plan, of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary must be made available by the plan

administrator, or the health insurance issuer offering such coverage, to the participant or beneficiary, in accordance with this section.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:28. Applicability and effective dates -- Group health plans. The requirements of §§ 20:06:58:01 to 20:06:58:45, inclusive, apply to a group health plan offering, medical or surgical benefits, and mental health or substance use disorder benefits. If, under an arrangement or arrangements to provide health care benefits by an employer or employee organization including for this purpose a joint board of trustees of a multiemployer trust affiliated with one or more multiemployer plans, any participant or beneficiary can simultaneously receive coverage for medical or surgical benefits and coverage for mental health or substance use disorder benefits, then the requirements of §§ 20:06:58:01 to 20:06:58:45, inclusive, apply separately with respect to each combination of medical or surgical benefits and of mental health or substance use disorder benefits, that any participant or beneficiary can simultaneously receive from that employer's or employee organization's arrangement or arrangements to provide medical care benefits, and all such combinations are considered for purposes of §§ 20:06:58:01 to 20:06:58:45, inclusive, to be a single group health plan.

This chapter applies to group health plans in accordance with 45 C.F.R. § 146.136(i)(1) (December 3, 2014).

Source:

General Authority: SDCL 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-18-79, 58-18-80.

20:06:58:29. Applicability and effective dates -- Health insurance issuers. The requirements of §§ 20:06:58:01 to 20:06:58:45, inclusive, apply to a health insurance issuer offering health insurance coverage for mental health or substance use disorder benefits in connection with a group health plan subject to § 20:60:58:28. This chapter applies to health insurance issuers offering group health insurance coverage in accordance with 45 C.F.R. § 146.136(i)(1) (December 3, 2014).

The requirements of §§ 20:06:58:01 to 20:06:58:45, inclusive, apply to health insurance coverage offered by health insurance issuer in the individual market in the same manner and to the same extent as such requirements apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the large group market. This chapter applies to health insurance issuers in the individual market in accordance with 45 C.F.R. § 147.160 (December 3, 2014). This chapter applies to non-grandfathered and grandfathered health plans.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:30. Scope. Sections 20:06:58:01 to 20:06:58:45, inclusive, do not:

(1) Require a group health plan, or health insurance issuer offering coverage in connection with a group health plan, to provide any mental health benefits or substance use disorder benefits, and the provision of benefits by a plan, or health insurance coverage, for one or more mental health conditions or substance use disorders does not require the plan, or health insurance coverage, under §§ 20:06:58:01 to 20:06:58:45, inclusive, to provide benefits for any other mental health condition or substance use disorder;

(2) Require a group health plan, or health insurance issuer offering coverage in connection with a group health plan, that provides coverage for mental health or substance use disorder benefits only to the extent required under 29 C.F.R. § 2713 (December 3, 2014) to provide additional mental health or substance use disorder benefits in any classification in accordance with §§ 20:06:58:01 to 20:06:58:45, inclusive; or

(3)Affect the terms and conditions relating to the amount, duration, or scope of mental health or substance use disorder benefits under the plan, or health insurance coverage, except as specifically provided in §§ 20:06:58:02 to 20:06:58:25, inclusive.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:31. Coordination with EHB requirements. Nothing in §§ 20:06:58:32 to 20:06:58:43, inclusive, changes the requirements of 45 CFR 147.150 and 45 CFR 156.115

(December 3, 2014), providing that a health insurance issuer offering non-grandfathered health insurance coverage in the individual or small group market providing mental health and substance use disorder services, including behavioral health treatment services, as part of essential health benefits required under 45 CFR 156.110(a)(5) and 156.115(a) (December 3 2014), must comply with the provisions of 45 CFR 146.136 (December 3, 2014) to satisfy the requirement to provide essential health benefits.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:32. Small employer exemption. The requirements of §§ 20:06:58:01 to 20:06:58:45, inclusive, do not apply to a group health plan, or health insurance issuer offering coverage in connection with a group health plan, for a plan year of a small employer. For purposes of §§ 20:06:58:32 and 20:06:58:33, the term, small employer, means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed at least a single individual, but not more than 50 employees on business days during the preceding calendar year and who employs at least a single individual on the first day of the plan year.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:33. Determining employer size. For purposes of § 20:06:58:32:

(1) All persons treated as a single employer under subsections (b), (c), (m), and (o) of the Internal Revenue Code of 1986, codified at 26 U.S.C. 414, are treated as one employer;

(2) If an employer was not in existence throughout the preceding calendar year, whether it is a small employer is determined based on the average number of employees the employer reasonably expects to employ on business days during the current calendar year; and

(3) Any reference to an employer for purposes of the small employer exemption includes a reference to a predecessor of the employer.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:34. Increased cost exemption. If the application of §§ 20:06:58:01 to 20:06:58:45, inclusive, to a group health plan, or health insurance coverage offered in connection with such plans, results in an increase for the plan year involved of the actual total cost of coverage with respect to medical or surgical benefits and mental health and substance use disorder benefits as determined and certified under § 20:06:58:36 by an amount that exceeds the applicable percentage described in § 20:06:58:36 of the actual total plan costs, the provisions of this section shall not apply to such plan, or coverage, during the following plan year, and such exemption shall apply to the plan, or coverage, for one plan year. An employer or issuer may elect to continue to provide mental health and substance use disorder benefits in compliance with this section with respect to the plan or coverage involved regardless of any increase in total costs.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:35. Applicable percentage. With respect to a plan or coverage, the applicable percentage described in §§ 20:06:58:34 to 20:06:58:43, inclusive, is:

(1) two percent in the case of the first plan year in which this section is applied to the plan or coverage; and

(2) one percent in the case of each subsequent plan year.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:36. Determinations by actuaries. Determinations as to increases in actual costs under a plan or coverage that are attributable to implementation of the requirements of §§ 20:06:58:01 to 20:06:58:45, inclusive, shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. All such determinations must be based on the formula specified in paragraph § 20:06:58:47 and shall be in a written report prepared by the actuary.

The group health plan or health insurance issuer shall maintain the written report described in this section, along with all supporting documentation relied upon by the actuary, for a period of six years following the notification made under § 20:06:58:39.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:37. Formula. The formula to be used to make the determination under § 20:06:58:36 is expressed mathematically as $[(E_1 – E_0)/T_0] – D > k$. The components mean:

(1) E_1 is the actual total cost of coverage with respect to mental health and substance use disorder benefits for the base period, including claims paid by the plan or issuer with respect to mental health and substance use disorder benefits and administrative costs, amortized over time, attributable to providing these benefits consistent with the requirements of §§ 20:06:58:01 to 20:06:58:45, inclusive;

(2) E_0 is the actual total cost of coverage with respect to mental health and substance use disorder benefits for the length of time immediately before the base period and that is equal in length to the base period, including claims paid by the plan or issuer with respect to mental health and substance use disorder benefits and administrative costs, amortized over time, attributable to providing these benefits;

(3) T_0 is the actual total cost of coverage with respect to all benefits during the base period;

(4) k is the applicable percentage of increased cost specified in paragraph § 20:06:58:35 that is expressed as a fraction for purposes of this formula; and

(5) D is the average change in spending that is calculated by applying the formula $(E_1 – E_0)/T_0$ to mental health and substance use disorder spending in each of the five prior years and then calculating the average change in spending.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:38. Six month determination. If a group health plan or health insurance issuer seeks an exemption under §§ 20:06:58:34 to 20:06:58:43, inclusive, determinations under § 20:06:58:36 may only be be made after such plan or coverage has complied with §§ 20:06:58:01 to 20:06:58:45, inclusive, for at least the first six months of the plan year involved.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:39. Notification. A group health plan or health insurance issuer that, based on the certification described under § 20:06:58:36, qualifies for an exemption under §§ 20:06:58:34 to 20:06:58:43, inclusive, and elects to implement the exemption, must notify participants and beneficiaries covered under the plan, the director, and the appropriate state agencies of such election.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:40. Participants and beneficiaries— Content of notice. The notice to participants and beneficiaries required pursuant to § 20:06:58:39 must include the following information:

(1) A statement that the plan or issuer is exempt from the requirements of this section and a description of the basis for the exemption;

(2) The name and telephone number of the individual to contact for further information;

(3) The plan or issuer name and plan number (PN);

(4) The plan administrator's name, address, and telephone number;

(5) For single-employer plans, the plan sponsor's name, address, and telephone number, if different from subdivision 3 of this section, and the plan sponsor's employer identification number (EIN);

(6) The effective date of such exemption;

(7) A statement regarding the ability of participants and beneficiaries to contact the plan administrator or health insurance issuer to see how benefits may be affected as a result of the plan's or issuer's election of the exemption; and

(8) A statement regarding the availability, upon request and free of charge, of a summary of the information on which the exemption is based, as required under § 20:06:58:43.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:41. Use of summary of material reductions in covered services or benefits. A plan or issuer may satisfy the requirements of § 20:06:58:40 by providing participants and beneficiaries, in accordance with § 20:06:58:42, with a summary of material reductions in covered services or benefits consistent with 29 CFR 2520.104b–3(d)(December 3, 2014) that also includes the information specified in § 20:06:58:40. However, in all cases, the exemption under §§ 20:06:58:34 to 20:06:58:43, inclusive, is not effective until 30 days after notice required pursuant to § 20:06:58:39 has been sent.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:42. Delivery. The plan or issuer is required to provide the notice described in §§ 20:06:58:40 to 20:06:58:43, inclusive, to all participants and beneficiaries. The plan or issuer may furnish the notice by any method of delivery that satisfies the requirements of section 104(b)(1) of ERISA (29 U.S.C. 1024(b)(1))(December 3, 2014) and its implementing regulations. If the notice is provided to the participant and any beneficiaries at the participant's last known address, then the requirements of §§ 20:06:58:40 to 20:06:58:43, inclusive, are satisfied with respect to the participant and all beneficiaries residing at that address. If a beneficiary's last known address is different from the participant's last known address, a separate notice is required to be provided to the beneficiary at the beneficiary's last known address.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:43. Availability of documentation. The plan or issuer must make available to participants and beneficiaries, or their representatives, on request and at no charge, a summary of the information on which the exemption was based. For purposes of §§ 20:06:58:34 to 20:06:58:43, inclusive, an individual who is not a participant or beneficiary and who presents a notice described in §§ 20:06:58:40 to 20:06:58:43, inclusive, is considered to be a representative. A representative may request the summary of information by providing the plan a copy of the notice provided to the participant under §§ 20:06:58:40 to 20:06:58:43, inclusive, with any personally identifiable information redacted. The summary of information must include the incurred expenditures, the base period, the dollar amount of claims incurred during the base period that would have been denied under the terms of the plan or coverage absent amendments required to comply with §§ 20:06:58:02 to 20:06:58:25, inclusive, the administrative costs related to those claims, and other administrative costs attributable to complying with the requirements of this section. In no event may the summary of information include any personally identifiable information.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:44. Sale of nonparity health insurance coverage. A health insurance issuer may not sell a policy, certificate, or contract of insurance that fails to comply with §§ 20:06:58:02 to 20:06:58:25, inclusive, except to a plan for a year for which the plan is exempt

from requirements of §§ 20:06:58:01 to 20:06:58:45, inclusive, because the plan meets requirements under §§ 20:06:40:70 and 20:06:40:71 or §§ 20:06:58:34 to 20:06:58:43, inclusive.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:58:45. Special effective date for certain collectively-bargained plans. For a group health plan maintained pursuant to one or more collective bargaining agreements ratified before October 3, 2008, the requirements of §§ 20:06:58:01 to 20:06:58:45, inclusive, do not apply to the plan, or health insurance coverage offered in connection with the plan, for plan years beginning before the date on which the last of the collective bargaining agreements terminates, determined without regard to any extension agreed to after October 3, 2008.

Source:

General Authority: SDCL 58-17-87, 58-18-79, 58-18-79(15).

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.