

20:06:09:48. ORSA guidance manual. The own risk and solvency assessment (ORSA) shall be conducted in accordance with the standards and requirements set forth in the National Association of Insurance Commissioners' ORSA Guidance Manual, ~~2014~~2017 edition.

Source: 44 SDR 71, effective October 23, 2017.

General Authority: SDCL ~~58-5A-53~~58-5A-93.

Law Implemented: SDCL 58-5A-1(8), 58-5A-82 to 58-5A-84, inclusive, 58-5A-93.

Reference: **National Association of Insurance Commissioners Own Risk and Solvency Assessment (ORSA) Guidance Manual, 2014** 2017 edition. Copies may be obtained from NAIC, 1100 Walnut Street, Ste. 1500, Kansas City, MO 64106-2197, (816) 783-8300.

CHAPTER 20:06:18

PRODUCER LICENSING

Section

20:06:18:01 Definitions.

20:06:18:01.01 Information management system.

20:06:18:02 Applicability.

20:06:18:03 Continuing education requirements for licensees.

20:06:18:03.01 Continuing education requirements for licensees obtaining new ~~qualifications~~
lines of authority.

20:06:18:04 Repealed.

20:06:18:04.01 Reciprocity between states.

20:06:18:05 Guidelines for filing for course approval.

20:06:18:05.01 Course attendance roster.

- 20:06:18:05.02 Forms used for course approval.
- 20:06:18:05.03 Guidelines for course renewal.
- 20:06:18:06 Certification of courses.
- 20:06:18:07 Unapproved course subject matter.
- 20:06:18:08 Courses specifically approved.
- 20:06:18:09 Maximum company-sponsored courses.
- 20:06:18:10 Independent study.
- 20:06:18:11 Repealed.
- 20:06:18:12 Electronic fee.
- 20:06:18:13 Time extension of continuing education requirements.
- 20:06:18:14 Instructor qualifications.
- 20:06:18:15 Grounds for revocation or denial of instructor status.
- 20:06:18:16 Course attendance -- Exceptions.
- 20:06:18:17 Advertisement of courses.
- 20:06:18:18 Carry-over of credits prohibited.
- 20:06:18:19 Effective date of producer appointments.
- 20:06:18:20 Maximum credit for a course during a two-year period.
- 20:06:18:21 Definition of initial pretrial hearing.
- 20:06:18:22 Prohibited compensation arrangements.

Appendix A Midwest Zone Declaration Regarding Continuing Education Course Approval, Including Midwest Zone Standard Continuing Education Filing Form, repealed, 31 SDR 67, effective November 14, 2004.

Appendix B Application for Course Approval and Instructor Qualification Form, repealed, 31 SDR 67, effective November 14, 2004.

20:06:18:03. Continuing education requirements for licensees. In each two-year period, a licensee shall fulfill the following continuing education requirements:

(1) Licensees who hold a property casualty ~~qualification~~ line of authority shall obtain at least ten CEC hours in courses certified as property/casualty;

(2) Licensees who hold a life, variable contract, or health ~~qualification~~ line of authority shall obtain at least ten CEC hours in courses certified as life/health;

(3) Licensees who hold only a crop hail ~~qualification~~ line of authority shall obtain at least four CEC hours in courses certified as crop hail;

(4) Licensees who hold both property/casualty and life/health ~~qualifications~~ lines of authority shall complete at least 20 CEC hours;

(5) Licensees who hold a crop hail ~~qualification~~ line of authority and only one of the ~~qualifications~~ lines of authority contained in subdivisions (1) and (2) shall obtain at least ten CEC hours. Two CEC hours must be in certified crop hail courses and only two CEC hours in certified crop hail courses will count towards the required ten CEC hours. If the licensee holds more than two ~~qualifications~~ lines of authority contained in subdivisions (1) and (2) including a crop hail ~~qualification~~ line of authority, the licensee shall complete at least 20 CEC hours with two of these CEC hours in certified crop hail courses. Only two CEC hours in certified crop hail courses will count towards the required ten CEC hours as contained in subdivision (1).

Source: 12 SDR 106, effective December 30, 1985; 12 SDR 151, 12 SDR 155, effective July 1, 1986; 31 SDR 67, effective November 14, 2004; 34 SDR 200, effective January 28, 2008;

36 SDR 127, effective March 1, 2010; 36 SDR 127, adopted February 8, 2010, effective May 1, 2010.

General Authority: SDCL ~~58-4-1~~, 58-30-117.

Law Implemented: SDCL 58-30-116, 58-30-117.

20:06:18:03.01. Continuing education requirements for licensees obtaining new ~~qualifications~~ lines of authority. Any licensee who obtains a new ~~qualification~~ line of authority during the licensee's two-year continuing education period does not need to fulfill the requirements of § 20:06:18:03 for the new ~~qualification~~ line of authority until the next two-year period.

Source: 36 SDR 127, adopted February 8, 2010, effective May 1, 2010.

General Authority: SDCL ~~58-4-1~~, 58-30-117.

Law Implemented: SDCL 58-30-116, 58-30-117.

20:06:18:17. Advertisement of courses. Continuing education courses may not be advertised as an approved course unless the division has approved the course in writing.

Courses which are advertised prior to formal approval, but after application has been made, shall contain the following statement or a substantially similar statement: "Application has been made for continuing education credit; however, this does not guarantee approval."

All advertising related to an approved course shall contain the following information:

- (1) The course title;
- (2) The approved sponsor of the course;
- (3) The ~~qualification~~ line of authority for which the course is approved (life/health, property/casualty, crop/hail, or general);
- (4) The number of approved continuing education credits; and

(5) A brief summary or outline of the course content.

The course sponsor shall provide a more detailed outline at no charge to anyone requesting it in writing.

Source: 19 SDR 160, effective April 27, 1993.

General Authority: SDCL 58-4-1, 58-30-117.

Law Implemented: SDCL 58-30-117, 58-30-119.

CHAPTER 20:06:22

LOSS RATIOS FOR HEALTH INSURANCE POLICIES

Section

20:06:22:01	Types of renewal clauses.
20:06:22:02	Anticipated loss ratio requirements -- Exception.
20:06:22:03	Rate filings.
20:06:22:04	Filings of rate revisions.
20:06:22:05	Requirements for history of experience.
20:06:22:06	Repealed.
20:06:22:07	Repealed.
20:06:22:08	Applicability of rules.
20:06:22:09	Repealed.
20:06:22:10	Repealed.
20;06:22:11	Repealed.
20:06:22:12	Repealed.
20:06:22:13	Repealed.

20:06:22:14 Repealed.

20:06:22:15 Repealed.

20:06:22:16 Repealed.

20:06:22:17 Repealed.

20:06:22:18 Repealed.

20:06:22:19 Repealed.

20:06:22:20 Repealed.

20:06:22:21 Repealed.

20:06:22:22 Repealed.

20:06:22:23 Repealed.

20:06:22:24 Repealed.

20:06:22:25 Repealed.

20:06:22:26 Repealed.

20:06:22:27 Rating bands.

20:06:22:27.01 Tobacco use defined.

20:06:22:27.02 Tobacco usage reporting.

20:06:22:28 Health status and gender factors precluded.

20:06:22:29 Rating area.

20:06:22:30 Rating variations.

20:06:22:31 Uniform age bands.

20:06:22:32 Single risk pool.

20:06:22:33 Index rate.

20:06:22:34 Permitted plan-level adjustments to the index rate.

20:06:22:35 Frequency of index rate and plan-level adjustments.

~~20:06:22:35~~ 20:06:22:36 Applicability.

Appendix A Formats For Reporting Rebate Calculations, repealed, 39 SDR 203, effective June 10, 2013.

Appendix B Credibility Tables, repealed, 39 SDR 203, effective June 10, 2013.

Appendix C Excerpts From The Supplemental Health Care Exhibit Instructions, repealed, 39 SDR 203, effective June 10, 2013.

20:06:22:35. Frequency of index rate and plan-level adjustments. A health insurance issuer may not establish an index rate and make the market-wide adjustments pursuant to 20:06:22:33, or make the plan-level adjustments pursuant to 20:06:22:33, more or less frequently than annually, except as provided in this section.

A health insurance issuer in the small group market may establish index rates and make the marketwide adjustments pursuant to 20:06:22:33, and make the plan-level adjustments pursuant to 20:06:22:33, no more frequently than quarterly. Any changes to rates must have effective dates of January 1, April 1, July 1, or October 1. Such rates may only apply to coverage issued or renewed on or after the rate effective date and will apply for the entire plan year of the group health plan.

Source: _____

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

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

~~20:06:22:35~~ **20:06:22:36. Applicability.** The provisions of §§ 20:06:22:27 to ~~20:06:22:34~~ 20:06:22:35, inclusive, apply for plan years beginning after December 31, 2013, in the small group market and for policy years beginning after December 31, 2013, for the individual market. The provisions of §§ 20:06:22:27 to ~~20:06:22:34~~ 20:06:22:35, inclusive, do not apply to grandfathered health plans.

Effective January 1, 2014, the provisions of §§ 20:06:22:27 to ~~20:06:22:34~~ 20:06:22:35, inclusive, apply to any individual plan, group, or small employer plan other than excepted benefits as defined in § 20:06:55:27 and grandfathered plans.

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

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

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

20:06:39:61. Annual open enrollment period. ~~For benefit years beginning on or after January 1, 2015,~~ the Health insurance issuers must provide an annual open enrollment period for the individual market outside the individual market Exchange begins November 15 and extends through February 15.

Source: 39 SDR 203, effective June 10, 2013; 41 SDR 93, effective December 3, 2014.

General Authority: SDCL 58-17-87.

Law Implemented: SDCL 58-17-87.

20:06:54:01. Coverage for preventive items and services. A group health plan, or a health insurance issuer offering group or individual health insurance coverage, shall provide coverage

for all of the following items and services, and may not impose any cost-sharing requirements such as a copayment, coinsurance, or deductible with respect to the following items or services:

(1) Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force as of ~~September 23, 2010~~ July 1 2018, and as appearing in Appendix A with respect to the individual involved;

(2) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;

(3) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

(4) With respect to women, to the extent not described in subdivision 20:06:54:01(1), evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

A health carrier shall at least annually at the beginning of each new plan year or policy year, whichever is applicable, revise the preventive services covered under its health insurance

policies pursuant to this section consistent with the recommendations of the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the guidelines with respect to infants, children, adolescents, and women, evidenced-based preventive care and screenings by the Health Resources and Services Administration in effect at the time.

Source: 37 SDR 63, effective September 23, 2010; 37 SDR 111, effective December 7, 2010.

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

Law Implemented: SDCL 58-17-1.1, 58-17-1.2, 58-17-62, 58-17-87, 58-17-98, 58-18-36, 58-18-41, 58-18-79, 58-18-80, 58-18-83.

Reference: The Guide to Clinical Preventive Services, 2009-2014. Recommendation of the U.S. Preventive Services Task Force. Copies can be obtained by contacting the Agency for Healthcare Research and Quality Publications Clearinghouse, on a single copy basis. Mail AHRQ Publications Clearinghouse, P.O. Box 8547, Silver Spring, MD 20907-8547. Online: <http://www.ahrq.gov/clinic/pocketgd09/pocketgd09.pdf> <http://www.ahrq.gov/>. Telephone: 800-358-9295, E-mail: ahrqpubs@ahrq.hhs.gov. You may also view online at <http://www.uspreventiveservicestaskforce.org/Page/Name/recommendations>.

CHAPTER 20:06:55

MARKET REGULATIONS

Section

- 20:06:55:01 Eligibility of children up to age 26.
- 20:06:55:02 Restrictions on plan definition of dependent.
- 20:06:55:03 Coverage of grandchildren not required.
- 20:06:55:04 Uniformity irrespective of age.
- 20:06:55:05 Individuals whose coverage ended by reason of reaching a dependent eligibility threshold -- Applicability.
- 20:06:55:06 Individuals whose coverage ended by reason of reaching a dependent eligibility threshold -- Opportunity to enroll required.
- 20:06:55:07 Individuals whose coverage ended by reason of reaching a dependent eligibility threshold -- Written notice.
- 20:06:55:08 Individuals whose coverage ended by reason of reaching a dependent eligibility threshold -- Effective date.
- 20:06:55:09 Individuals whose coverage ended by reason of reaching a dependent eligibility threshold -- Group health plan special enrollee.
- 20:06:55:10 Special rule for grandfathered group health plans.
- 20:06:55:11 Applicability.
- 20:06:55:12 Choice of primary care providers.
- 20:06:55:13 Emergency services.
- 20:06:55:14 Rescissions.
- 20:06:55:15 Group plans -- Lifetime limits.
- 20:06:55:16 Group plans -- Annual limits.
- 20:06:55:17 Group plans -- Eligibility.
- 20:06:55:18 Group plans -- Notices and enrollment.

20:06:55:19 Group plans -- Special enrollment.

20:06:55:20 Group plans -- Applicability.

20:06:55:21 Individual plans -- Lifetime limits.

20:06:55:22 Individual plans -- Annual limits.

20:06:55:23 Reinstatement of coverage.

20:06:55:24 Individual plans -- Applicability.

20:06:55:25 Individual plans -- No preexisting condition for a person under the age of 19 -- Open enrollment. Repealed January 1, 2014.

20:06:55:25.01 Individual plans -- No preexisting condition.

20:06:55:26 Group plans -- No preexisting condition.

20:06:55:27 Excepted benefits -- Defined.

20:06:55:28 Disproportionate share reporting. Repealed January 1, 2014.

20:06:55:29 Disproportionate share based on loss ratio. Repealed January 1, 2014.

20:06:55:30 Disproportionate share based upon covered lives. Repealed January 1, 2014.

20:06:55:31 Length of disproportionate share approval. Repealed January 1, 2014.

20:06:55:32 Definitions.

20:06:55:33 Certifying qualified health plans.

20:06:55:34 Issuer standards and certification criteria.

20:06:55:35 Qualified health plan defined.

20:06:55:36 Exchange network adequacy standards.

20:06:55:37 Network adequacy standards.

20:06:55:38 Essential community providers defined.

20:06:55:39 Essential community providers.

20:06:55:40 Payment of federally-qualified health centers.

- 20:06:55:41 Treatment of direct primary care medical homes.
 - 20:06:55:42 Recertification of qualified health plans.
 - 20:06:55:43 Decertification of qualified health plan.
 - 20:06:55:44 Non-renewal and decertification of qualified health plans.
 - 20:06:55:45 Rates.
 - 20:06:55:46 Health plan applications and notices.
 - 20:06:55:47 Accreditation of qualified health plan issuers.
 - 20:06:55:48 ~~Initial open enrollment period~~ Repealed.
 - 20:06:55:49 Annual open enrollment period.
 - 20:06:55:50 Changing qualified health plans.
 - 20:06:55:50.01 Loss of coverage.
 - 20:06:55:50.02 Special enrollment period effective dates.
 - 20:06:55:51 Compensation.
 - 20:06:55:52 Plan offerings in the exchange.
 - 20:06:55:53 Applicability and effective dates.
- Appendix A Model Choice of Health Care Professional Notice Language.

20:06:55:42. Recertification of qualified health plans. Each qualified health plan offered in an Exchange must obtain annual recertification from the director in accordance with the criteria as outlined in § 20:06:55:35 ~~by September 15th~~ of each year. Upon determining the recertification status of a qualified health plan the director shall notify qualified health plan issuers.

If a qualified health plan issuer elects not to seek recertification with an Exchange for its qualified health plan, the qualified health plan issuer must provide written notice of the election to each enrollee.

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.

20:06:55:48. Initial open enrollment period. ~~A health insurance issuer must provide for an initial open enrollment period in the individual market Exchange beginning October 1, 2013, and extending through March 31, 2014. Effective coverage dates for initial open enrollment period must be as follows:~~

~~—— (1) For a person enrolling on or before December 15, 2013, the issuer must make the coverage effective January 1, 2014;~~

~~—— (2) For a person enrolling between the first and fifteenth day of any month between January 2014 and March 2014, the issuer must make a coverage effective on the first day of the following month; and~~

~~—— (3) For a person enrolling between the sixteenth and last day of the month for any month between December 2013 and March 31, 2014, the issuer must make a coverage effective on the first day of the second following month. Repealed.~~

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.~~

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

Source: 39 SDR 203, adopted June 10, 2013, effective January 1, 2014; 41 SDR 93, effective December 3, 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 (QHP) to another as a result of the following triggering events:

(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~~ such coverage. The date of the loss of coverage is the ~~date in 2014 of the expiration of the non-calendar year policy~~ last day of the plan or policy year;

(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) (July 1, 2018). 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—;~~

(2) The qualified individual:

(i) Gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, placement in foster care, or through a child support order or other court order;

(a) In the case of marriage, at least one spouse must demonstrate having minimum essential coverage for 1 or more days during the 60 days preceding the date of marriage.

(ii) Loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by State law in the State in which the divorce or legal separation occurs, or if the enrollee, or his or her dependent, dies.

(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 and had minimum essential coverage as described in 26 CFR 1.5000A-1(b) for one or more days during the 60 days preceding the date of the permanent move;

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

(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 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.~~

(9) Newly eligible or ineligible for advance payments of the premium tax credit, or change in eligibility for cost-sharing reductions:

(i) The enrollee 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;

(ii) The enrollee's dependent enrolled in the same QHP 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; or

(iii) A qualified individual or his or her 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) (April 15, 2016), including

as a result of their employer discontinuing or changing available coverage within the next 60 days, provided that such individual is allowed to terminate existing coverage;

(iv) A qualified individual in a non-Medicaid expansion State who was previously ineligible for advance payments of the premium tax credit solely because of a household income below 100 percent of the FPL, who was ineligible for Medicaid during that same timeframe, and who has experienced a change in household income that makes the qualified individual newly eligible for advance payments of the premium tax credit.

(10) Is a victim of domestic abuse or spousal abandonment, as defined by 26 CFR 1.36B-2T, as amended, including a dependent or unmarried victim within a household, is enrolled in minimum essential coverage and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment; or is a dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, may enroll in coverage at the same time as the victim;

(11) Applies for coverage on the Exchange during the annual open enrollment period or due to a qualifying event, is assessed by the Exchange as potentially eligible for Medicaid or the Children's Health Insurance Program (CHIP), and is determined ineligible for Medicaid or CHIP by the State Medicaid or CHIP agency either after open enrollment has ended or more than 60 days after the qualifying event or applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHIP after open enrollment has ended;

(12) The qualified individual or enrollee, or his or her dependent, adequately demonstrates to the Exchange that a material error related to plan benefits, service area, or premium influenced the qualified individual's or enrollee's decision to purchase a QHP through the Exchange; or

(13) At the option of the Exchange, the qualified individual provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a QHP through the Exchange following termination of Exchange enrollment due to a failure to verify such status within the time period specified in § 155.315 or is under 100 percent of the FPL and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence.

A qualified individual or enrollee has 60 days from the date of a triggering event to select a ~~qualified health plan~~ QHP. 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~~ QHP. 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~~ QHP.

Source: 39 SDR 203, adopted June 10, 2013, effective January 1, 2014; 41 SDR 93, effective December 3, 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, 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 month following plan selection;

(5) In the case of a qualified individual or enrollee eligible for a special enrollment period as described in §§ 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;

(7) In the case of a court order the plan must ensure that coverage is effective for a qualified individual or enrollee on the date the court order is effective, or it may permit the qualified individual or enrollee to elect a coverage effective date in accordance with subdivision 1. If the Exchange permits the qualified individual or enrollee to elect a coverage effective date in accordance with subparagraph 1 of this section, the Exchange must ensure coverage is effective on the date duly selected by the qualified individual or enrollee; and

(8) If an enrollee or his or her dependent dies, the plan must ensure that coverage is effective on the first day of the month following the plan selection, or it may permit the enrollee or his or her dependent to elect a coverage effective date in accordance with subdivision 1. If the Exchange permits the enrollee or his or her dependent to elect a coverage effective date in accordance with subdivision 1 of this rule, the Exchange must ensure coverage is effective on the date duly selected by the enrollee or his or her dependent.

Source: 39 SDR 203, adopted June 10, 2013, effective January 1, 2014; 41 SDR 93, effective December 3, 2014.

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

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