**20:06:13:02.  Definitions.** Terms defined in SDCL 58-17A-1 have the same meaning when used in this chapter. In addition, terms used in this chapter mean:

(1)  "1990 Standardized Medicare supplement benefit plan," a group or individual policy of Medicare supplement insurance issued after July 16, 1992, and prior to June 1, 2010, and includes Medicare supplement insurance policies and certificates renewed during that period which are not replaced by the issuer at the request of the insured;

(2)  "2010 Standardized Medicare supplement benefit plan," a group or individual policy of Medicare supplement insurance issued after May 31, 2010;

(3)  "Bankruptcy," when a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state;

(4)  "Benefit period" or "Medicare benefit period," as defined in the Medicare program, 42 U.S.C. § 1395 et seq, as in effect on July 1, 1992;

(5)  "Buyer's guide," the informational brochure as approved by the director;

(6)  "Complaint," dissatisfaction expressed by an individual concerning a Medicare select issuer or its network providers;

(7)  "Continuous period of creditable coverage," the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than 63 days;

(8)  "Convalescent nursing home," "extended care facility," or "skilled nursing facility," as defined in the Medicare program, 42 U.S.C. § 1395 et seq, as in effect on July 1, 1992;

(9)  "Employee welfare benefit plan," a plan, fund, or program of employee benefits as defined in 29 U.S.C. § 1002 (Employee Retirement Income Security Act), as in effect on September 1, 1998;

(10)  "Grievance," dissatisfaction with the administration, claims practices, or provision of services by a Medicare select issuer or its network providers that is expressed in writing by an individual insured under a Medicare select policy or certificate;

(11)  "Health care expenses," expenses of a health maintenance organization associated with the delivery of health care services, and which are analogous to the incurred losses of insurers;

(12)  "Hospital," as defined in the Medicare program, 42 U.S.C. § 1395 et seq, as in effect on July 1, 1992;

(13)  "Insolvency," when an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile;

(14)  "Medicare Advantage plan," a plan of coverage for health benefits under Medicare Part C as defined in the Medicare program, 42 U.S.C. § 1395 et seq and includes:

(a)  Coordinated care plans that provide health care services, including health maintenance organization plans, plans offered by provider-sponsored organizations, and preferred provider organization plans;

(b)  Medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account; and

(c)  Medicare Advantage private fee-for-service plans;

(15)  "Medicare select issuer," an issuer offering or seeking to offer a Medicare select policy or certificate;

(16)  "Medicare select policy" or "Medicare select certificate," a Medicare supplement policy or a Medicare supplement certificate that contains restricted network provisions;

(17)  "NAIC," National Association of Insurance Commissioners;

(18)  "Network provider," a provider of health care or a group of providers of health care which has entered into a written agreement with the issuer to provide benefits insured under a Medicare select policy;

(19)  "Physician," may not be defined more restrictively than as defined in the Medicare program;

(20)  "Pre-standardized Medicare supplement benefit plan," a group or individual policy of Medicare supplement insurance issued prior to July 17, 1992;

(21)  "Restricted network provision," any provision which conditions the payment of benefits, in whole or in part, on the use of network providers;

(22)  "Secretary of Health and Human Services," the secretary of the United States Department of Health and Human Services;

(23)  "Service area," the geographic area within which an issuer is authorized to offer a Medicare select policy;

(24)  "Sickness," illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force;

(25)  "Type," an individual policy or a group policy;

**Source:** 8 SDR 174, effective July 1, 1982; 12 SDR 151, 12 SDR 155, effective July 1, 1986; 15 SDR 143, effective March 29, 1989; 16 SDR 174, effective May 2, 1990; 18 SDR 225, effective July 17, 1992; 22 SDR 107, effective February 18, 1996; 23 SDR 236, effective July 13, 1997; 25 SDR 44, effective September 30, 1998; 26 SDR 26, effective September 1, 1999; 27 SDR 53, 27 SDR 54, effective December 4, 2000; 28 SDR 157, effective May 19, 2002; 31 SDR 214, effective July 6, 2005; 35 SDR 183, effective February 2, 2009.

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