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RATE SHEET
STATE OF SOUTH DAKOTA

Base Plan		*Options*	
Facility Monthly Benefit	**$1,000**	Home Care Level	**Total**
Home Monthly Benefit	**$500**	Inflation Protection	**Compound Uncapped**
Facility Benefit Duration	**2 Years**		
Home Benefit	**50%**		
Lifetime Maximum	**$24,000**		
Elimination Period	**90 Days**		
Home Care Level	**Professional**		

This rate sheet shows the cost per $1,000 of coverage

Calculate your Premium:

_____ Rate for Plan Chosen X _____ Facility Monthly Benefit Amount ÷ $1,000 = _____ **(A)** Your Premium

For Employees Only:

_____ Rate for Plan 1 (2 Year Duration) X 1.5 (Based on Funded Amount) = _____ **(B)** Employer Paid Amount

A MINUS B = _____ **EMPLOYEE'S COST**

Monthly Rates

Insurance Age	Plan 1 Base Plan	Plan 2 Base Plan With Total Home Care Option	Plan 3 Base Plan With Compound Inflation Option	Plan 4 Base Plan With Total Home Care Compound Inflation Option
18-30	2.00	3.00	6.50	9.00
31	2.10	3.20	6.80	9.30
32	2.10	3.20	7.10	9.70
33	2.10	3.30	7.20	9.90
34	2.30	3.50	7.50	10.30
35	2.40	3.50	7.70	10.40
36	2.50	3.70	7.90	10.70
37	2.50	3.80	8.10	11.00
38	2.60	3.90	8.40	11.30
39	2.70	4.10	8.50	11.60
40	2.80	4.20	8.70	11.80
41	2.90	4.40	9.00	12.20
42	3.10	4.60	9.50	12.80
43	3.30	4.90	9.80	13.20
44	3.50	5.10	10.10	13.60
45	3.60	5.20	10.30	13.90
46	3.80	5.60	10.80	14.50
47	4.00	5.90	11.10	14.90
48	4.20	6.20	11.30	15.30
49	4.50	6.60	11.70	16.00
50	4.80	7.00	12.20	16.60
51	5.00	7.40	12.60	17.20
52	5.30	7.90	12.90	17.80
53	5.50	8.30	13.40	18.60
54	5.90	8.90	13.90	19.20
55	6.20	9.40	14.50	19.90
56	6.70	10.00	15.10	20.70
57	7.20	10.70	15.90	21.70
58	7.80	11.50	16.70	22.80
59	8.30	12.30	17.50	23.80

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RATE SHEET
STATE OF SOUTH DAKOTA

Base Plan		*Options*	
Facility Monthly Benefit	**$1,000**	Home Care Level	**Total**
Home Monthly Benefit	**$500**	Inflation Protection	**Compound Uncapped**
Facility Benefit Duration	**2 Years**		
Home Benefit	**50%**		
Lifetime Maximum	**$24,000**		
Elimination Period	**90 Days**		
Home Care Level	**Professional**		

This rate sheet shows the cost per $1,000 of coverage

Calculate your Premium:

_____ X _____ ÷ $1,000 = _____ **(A)**
Rate for Plan Chosen — Facility Monthly Benefit Amount — Your Premium

For Employees Only:

_____ X 1.5 = _____ **(B)**
Rate for Plan 1 (2 Year Duration) — (Based on Funded Amount) — Employer Paid Amount

A MINUS B = _____
EMPLOYEE'S COST

Monthly Rates

Insurance Age	Plan 1 Base Plan	Plan 2 Base Plan With Total Home Care Option	Plan 3 Base Plan With Compound Inflation Option	Plan 4 Base Plan With Total Home Care Compound Inflation Option
60	9.00	13.20	18.50	25.10
61	9.80	14.20	19.90	26.80
62	10.80	15.60	21.30	28.60
63	12.00	17.00	22.90	30.50
64	13.10	18.30	24.60	32.40
65	15.00	20.60	27.60	35.80
66	16.60	22.40	29.90	38.30
67	18.50	24.60	32.50	41.30
68	20.50	26.90	35.10	44.10
69	22.60	29.30	38.00	47.30
70	25.20	32.10	41.00	50.50
71	28.00	35.20	44.90	54.70
72	31.00	38.50	48.90	59.00
73	34.50	42.40	53.10	63.70
74	38.20	46.40	57.60	68.50
75	46.00	55.40	68.00	80.30
76	50.50	60.30	73.90	86.50
77	55.60	65.60	79.60	92.40
78	60.90	71.30	86.10	99.10
79	66.90	77.60	92.60	105.90
80	73.40	84.40	100.10	113.70

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RATE SHEET
STATE OF SOUTH DAKOTA

Base Plan		*Options*	
Facility Monthly Benefit	**$1,000**	Home Care Level	**Total**
Home Monthly Benefit	**$500**	Inflation Protection	**Compound Uncapped**
Facility Benefit Duration	**6 Years**		
Home Benefit	**50%**		
Lifetime Maximum	**$72,000**		
Elimination Period	**90 Days**		
Home Care Level	**Professional**		

This rate sheet shows the cost per $1,000 of coverage

Calculate your Premium:

_____ Rate for Plan Chosen X _____ Facility Monthly Benefit Amount ÷ $1,000 = _____ **(A)** Your Premium

For Employees Only:

_____ Rate for Plan 1 (2 Year Duration) X 1.5 (Based on Funded Amount) = _____ **(B)** Employer Paid Amount

A MINUS B = _____ **EMPLOYEE'S COST**

Monthly Rates

Insurance Age	Plan 1 Base Plan	Plan 2 Base Plan With Total Home Care Option	Plan 3 Base Plan With Compound Inflation Option	Plan 4 Base Plan With Total Home Care Compound Inflation Option
18-30	3.60	5.60	11.50	16.20
31	3.70	5.70	11.90	16.70
32	3.80	5.80	12.10	17.00
33	3.90	5.90	12.50	17.40
34	3.90	6.00	12.80	17.90
35	4.20	6.30	13.20	18.40
36	4.30	6.50	13.40	18.70
37	4.40	6.70	13.90	19.30
38	4.60	7.00	14.40	20.00
39	4.70	7.20	14.70	20.40
40	5.00	7.50	15.20	21.00
41	5.10	7.80	15.50	21.60
42	5.40	8.20	16.00	22.20
43	5.60	8.50	16.50	22.80
44	6.00	9.00	17.10	23.70
45	6.30	9.40	17.70	24.40
46	6.70	10.00	18.30	25.30
47	6.90	10.50	18.70	26.00
48	7.30	11.20	19.40	27.10
49	7.50	11.70	19.90	27.90
50	8.00	12.40	20.40	28.90
51	8.40	13.10	21.10	30.00
52	8.90	13.90	21.80	31.20
53	9.50	14.80	22.60	32.50
54	10.00	15.70	23.40	33.70
55	10.70	16.80	24.40	34.80
56	11.40	17.90	25.50	36.40
57	12.10	19.10	26.60	38.20
58	13.00	20.50	27.80	40.00
59	14.00	22.00	29.10	41.90

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RATE SHEET
STATE OF SOUTH DAKOTA

Base Plan		*Options*	
Facility Monthly Benefit	**$1,000**	Home Care Level	**Total**
Home Monthly Benefit	**$500**	Inflation Protection	**Compound Uncapped**
Facility Benefit Duration	**6 Years**		
Home Benefit	**50%**		
Lifetime Maximum	**$72,000**		
Elimination Period	**90 Days**		
Home Care Level	**Professional**		

This rate sheet shows the cost per $1,000 of coverage

Calculate your Premium:

_____ X _____ ÷ $1,000 = _____(A)

Rate for Plan Chosen — Facility Monthly Benefit Amount — Your Premium

For Employees Only:

_____ X 1.5 = _____(B)

Rate for Plan 1 (2 Year Duration) — (Based on Funded Amount) — Employer Paid Amount

A MINUS B = _____

EMPLOYEE'S COST

Monthly Rates

Insurance Age	Plan 1 Base Plan	Plan 2 Base Plan With Total Home Care Option	Plan 3 Base Plan With Compound Inflation Option	Plan 4 Base Plan With Total Home Care Compound Inflation Option
60	15.00	23.50	30.50	44.00
61	16.40	25.70	32.80	47.20
62	17.90	27.90	35.20	50.50
63	19.70	30.40	37.50	53.60
64	21.70	33.10	40.40	57.50
65	24.60	37.10	44.80	63.20
66	27.20	40.50	48.50	67.80
67	30.20	44.30	52.80	73.10
68	33.30	48.30	56.90	77.90
69	36.90	52.70	61.40	83.60
70	40.80	57.70	66.20	89.50
71	45.30	63.30	72.40	97.00
72	50.30	69.40	78.70	104.60
73	55.50	76.10	85.00	112.50
74	61.30	83.20	92.20	121.10
75	73.80	99.40	108.70	141.90
76	81.10	108.20	117.90	152.80
77	88.90	117.70	126.80	163.30
78	97.50	128.10	137.00	175.30
79	106.90	139.50	147.20	187.70
80	117.20	151.70	159.30	201.80

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RATE SHEET
STATE OF SOUTH DAKOTA

Base Plan		*Options*	
Facility Monthly Benefit	**$1,000**	Home Care Level	**Total**
Home Monthly Benefit	**$500**	Inflation Protection	**Compound Uncapped**
Facility Benefit Duration	**Unlimited**		
Home Benefit	**50%**		
Lifetime Maximum	**Unlimited**		
Elimination Period	**90 Days**		
Home Care Level	**Professional**		

This rate sheet shows the cost per $1,000 of coverage

Calculate your Premium:

_____ Rate for Plan Chosen X _____ Facility Monthly Benefit Amount ÷ $1,000 = _____ **(A)** Your Premium

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A MINUS B = _____ **EMPLOYEE'S COST**

Monthly Rates

Insurance Age	Plan 1 Base Plan	Plan 2 Base Plan With Total Home Care Option	Plan 3 Base Plan With Compound Inflation Option	Plan 4 Base Plan With Total Home Care Compound Inflation Option
18-30	5.00	8.00	15.50	22.60
31	5.00	8.00	15.80	23.10
32	5.10	8.20	16.20	23.50
33	5.20	8.30	16.60	24.20
34	5.40	8.60	17.00	24.70
35	5.60	8.90	17.40	25.30
36	5.70	9.10	17.90	25.90
37	5.90	9.40	18.40	26.60
38	6.10	9.70	18.80	27.20
39	6.40	10.10	19.50	28.10
40	6.60	10.50	20.00	28.80
41	7.00	10.90	20.70	29.70
42	7.30	11.40	21.20	30.50
43	7.60	11.90	21.80	31.40
44	7.90	12.40	22.50	32.30
45	8.30	13.10	23.20	33.30
46	8.70	13.80	23.90	34.50
47	9.20	14.60	24.50	35.60
48	9.70	15.50	25.40	37.10
49	10.10	16.30	25.90	38.20
50	10.70	17.30	26.70	39.70
51	11.20	18.30	27.60	41.20
52	11.80	19.50	28.50	42.80
53	12.50	20.80	29.60	44.80
54	13.20	22.00	30.40	46.20
55	13.80	23.20	31.40	47.40
56	14.80	24.80	32.70	49.60
57	15.80	26.60	34.30	52.30
58	16.80	28.50	35.60	54.60
59	18.10	30.50	37.30	57.30

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Facility Benefit Duration	**Unlimited**		
Home Benefit	**50%**		
Lifetime Maximum	**Unlimited**		
Elimination Period	**90 Days**		
Home Care Level	**Professional**		

This rate sheet shows the cost per $1,000 of coverage

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Monthly Rates

Insurance Age	Plan 1 Base Plan	Plan 2 Base Plan With Total Home Care Option	Plan 3 Base Plan With Compound Inflation Option	Plan 4 Base Plan With Total Home Care Compound Inflation Option
60	19.40	32.80	38.90	60.20
61	21.10	35.70	41.70	64.40
62	23.10	38.90	44.70	69.10
63	25.20	42.30	47.50	73.40
64	27.50	46.10	50.80	78.50
65	31.10	51.40	56.20	86.20
66	34.50	56.30	61.00	92.70
67	38.10	61.50	66.10	99.70
68	42.20	67.20	71.20	106.50
69	46.60	73.30	77.10	114.40
70	51.40	79.90	82.90	122.30
71	57.10	87.70	90.50	132.40
72	62.90	95.70	98.10	142.30
73	69.40	104.60	105.80	152.90
74	76.50	114.10	114.40	164.10
75	91.80	135.80	134.60	191.80
76	100.80	147.70	146.00	206.60
77	110.50	160.60	157.00	220.70
78	120.80	174.50	169.30	236.40
79	132.30	189.60	181.70	252.80
80	144.80	205.80	196.20	271.30