ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE REPEALING, RENUMBERING, RENUMBERING AND AMENDING, AMENDING, REPEALING AND RECREATING AND CREATING A RULE

To repeal Ins 3.39 (33); to renumber Ins 3.39 (34) (c) 6., to renumber and amend Ins 3.39 (23) (a) 6., and (30) (s) and (t); to amend Ins 3.39 (1) (c); (4) (intro.), (4) (a) 1., 2., 3., 6., 12., 18m. and 18r. b, (4m) (a), (b) and (d), (5) (c) 6., 12., 13., 14., 15., (i) (intro.) and 7., (j), (k) (intro.), (m) (intro.), (14) (a), (c) 6., (j) and (m), (15), (16) (a), (c) (intro.), 1. and 3., and (e), (21) (a) and (e), (22) (a), (b), (c) (d), (e), (f) (intro.) and 1., (23) (a) (intro.), 1., 3. and 4., and (c), (25) (a), (b) and (c), (26), (27), (29), (30) (a) 1. and 2., (b) 1. – 7., (c), (d), (e) (intro.), (f) 1., (g), (h), (i) (intro.), 1. b, 3., 7., and 9., (j), (k), (L), (m) 1. and 2., (n) (intro.), 1., and 2., (o), (p) (intro.) and 8., (34) (a) (intro.), 1. and 2., (b) 1., 1m., 2. (intro.), 4. (intro.), 5. a, and 6., (c) 1. (intro.), 1. a, 2. and 4., (e) and (f), Appendix 5, Appendix 8, 18.02 (1) and 18.10 (3); to repeal and recreate Ins 3.39 (3), (7), (22) (i), Appendix 1, Appendix 3, Appendix 4, and Appendix 6; and to create Ins 3.39 (2) (f), (4) (a) 20. and 21., (5) (n) and (o), (23) (a) 5., (30) (q) and (r), (34) (b) 1r., 7. and 8., and (34) (c) 5., Wis. Adm. Code, relating to Medicare supplement, replacement, cost and select, Medicare Advantage and Medicare D prescription drug plans.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE (OCI)

1. Statutes interpreted:

ss. 185.983 (1m), 600.03, 601.01 (2), 609.01 (1g) (b), 625.16, 628.34 (12), 628.38, 631.20 (2), 632.73 (2m), 632.76 (2) (b) and 632.81, 632.895 (6) and (9), Wis. Stats.

2. Statutory authority:

ss. 601.41, 625.16, 628.34, 628.38, 632.73, 632.76, 632.81, Wis. Stats.

3. Explanation of the OCI's authority to promulgate the proposed rule under these statutes:

The statutes all relate to the commissioner's authority to promulgate rules regulating the business of insurance as it relates to Medicare supplement and Medicare replacement insurance products. Specifically, ss. 601.41, 625.16, 628.38, 632.73, 632.76, and 632.81, Wis. Stats., permit the commissioner to promulgate rules regulating various aspects of Medicare supplement and Medicare replacement products while ss. 628.34, and 628.38, Wis. Stats.,

authorize the commissioner to promulgate rules governing disclosure requirements and unfair marketing practices for disability policies, which includes Medicare supplement and Medicare replacement products.

4. Related Statutes or rules:

The Centers For Medicare & Medicaid Services (CMS) has delegated to the National Association of Insurance Commissioners, (NAIC) the function implementing the Medicare Prescription Drugs, Improvement and Modernization Act (MMA) of 2003. CMS delegates enforcement of MMA and the underlying Medicare supplement and Medicare replacement insurance products to the states that have incorporated into the states insurance regulations, the NAIC Model Act. To date Wisconsin has passed through statute and most frequently administrative rule, NAIC Model Act governing the Medicare supplement and Medicare replacement products. In Wisconsin Medicare supplement and Medicare replacement products are currently regulated through s. Ins 3.39, Wis. Adm. Code, inclusive of the appendices. The proposed rule modifies s. Ins 3.39, Wis. Adm. Code, and several appendices in order to comply with the MMA and NAIC requirements, to the extent necessary, and updates the appendices to reflect current requirements.

5. The plain language analysis and summary of the proposed rule:

The proposed rule implements modifications required by the NAIC Medicare Supplement Insurance Minimum Standards Model Act. The rule broadens and clarifies guarantee issue rights for persons who are also Medicaid eligible or who are or were insured by an employer sponsored health insurance plan. The MMA also created Medicare Part D for outpatient prescription drug coverage and requires the states to mandate modifications in Medicare supplement and Medicare replacement policies to ensure that benefits are not duplicated. The rule preserves the regulatory oversight of products primarily sold to Wisconsin seniors and maintains rigorous standards for disclosures benefits, consumer rights and marketing practices.

Medigap policies are policies purchased by Medicare beneficiaries to cover Medicare deductibles, co-insurance and selected services that Medicare does not cover. Medicare establishes eligibility rules, benefits and coverage limits. The proposed rule incorporates the NAIC Model Act into Wisconsin's current Medicare supplement and Medicare replacement rules. In compliance with the MMA, the rule proposes to create two cost-sharing Medicare supplement policies and two cost-sharing Medicare select policies and rename Medicare + Choice to Medicare Advantage. As a result of the additional new cost-sharing plans, the existing Medicare supplement insurance high deductible plan and high deductible drug plan will no longer be permitted to be sold after December 31, 2005. The rule revises the standards for Medicare supplement and Medicare replacement plans to eliminate outpatient prescription drug coverage for those who enroll in Medicare Part D; and prohibits the sale of outpatient prescription drug coverage in Medigap policies after December 31, 2005, when Medicare Part D comes into effect.

The proposed rule allows individuals currently covered by Medicare supplement and Medicare replacement policies that provide outpatient prescription drug coverage the opportunity to maintain their current coverage. However, the federal MMA states that insured individuals who choose to maintain existing coverage with the drug benefit will be subject to a penalty if they decide to apply for Medicare Part D coverage after January 1, 2006. This modification is significant as current Wisconsin regulation requires Medicare supplement and Medicare replacement policies to include a catastrophic coverage for 80% of outpatient prescription drug charges that exceed $6,250 per calendar year and provides that plans may offer an option outpatient prescription drug rider. The removal of the drug benefit is required so as not to duplicate the benefit offered through the newly created Medicare Part D.

Additionally, Wisconsin issuers of Medicare supplement and Medicare replacement policies are currently required to cover as basic benefits several state mandated benefits

including but not limited to diabetic supplies and equipment, skilled nursing home stays, and HIV prescription drugs. In order to comply with MMA, some of these benefits are amended in the proposed rule and the mandate for covering outpatient prescription medications is deleted.

The proposed rule repeals and recreates the requirements for Medicare cost plans due to a change of enforcement position by CMS. The proposed rule revises the basic benefit requirements for Medicare cost plans by removing all requirements that would add benefits beyond what is covered by Medicare. Medicare cost plans may continue to offer "enhanced" plans, but most also offer the option of purchasing a Medicare cost "basic" product.

The proposed rule clarifies for Medicare supplement, Medicare select and enhanced Medicare cost plans that OCI requires issuers to pay for inpatient hospitalization expenses (under Medicare Part A) at the Medicare reimbursement rate, a change that will limit issuers financial exposure on prolonged hospitalizations. Additionally, the proposed rule clarifies that the skilled nursing home benefit mandated by Wisconsin statute is an additional benefit and that an issuer cannot count as meeting the mandate the co-payment required under Medicare Part B. Rather, the proposed rule clarifies that the Wisconsin mandate is a separate additional benefit to insureds. Other modifications to Ins. 3.39, Wis. Adm. Code, include the addition of specific reference to Medicare select and Medicare cost plans where appropriate. Due to heightened concern for seniors, the rule also clarifies that it is improper and unnecessary for a senior to have more than one Medicare supplement, Medicare select, Medicare cost or Medicare Advantage plan at any one time.

Finally, the rule includes modifications to several appendices. With the addition of four cost-sharing plans and the change to basic Medicare cost plans, the current outline of coverage contained in Appendix 1 was inadequate to sufficiently and accurately represent the benefits and describe to seniors what the various types of Medicare supplement or Medicare

replacement products offer. Although proposed the outlines of coverage are presented now in four subparts, Appendix 1 will provide issuers and consumers clear information and disclosures regarding the products. Five additional appendices -- Appendix 3, 4, 5, 6 and 8 – are revised to reflect changes in the NAIC Model Act or to reflect current reporting requirements of the commissioner.

6. Summary of and preliminary comparison with any existing or proposed federal regulation that is intended to address the activities to be regulated by the proposed rule:

The NAIC Model Act implements MMA and previous federal Medicare supplement and Medicare replacement regulations. CMS delegated to the states through NAIC regulation of insurers offering Medicare supplement and Medicare replacement plans. Currently states are preempted from regulating Medicare + Choice plans and will be prohibited from requiring state mandated benefits in the Medicare cost basic product.

7. Comparison of similar rules in adjacent states as found by OCI:

Iowa: Iowa makes available to its Medicare beneficiaries Medigap policies A through J as required by the Medicare reform provisions under OBRA 1990 and the prior NAIC Model Regulation. Iowa will have to amend its regulations to create new Medigap plans K and L, and to eliminate prescription drug coverage under its standard H, I and J Medigap policies for those who enroll in Medicare Part D. It also will have to amend its regulations to include the prohibitions and other changes under MMA.

Illinois: Illinois makes available to its Medicare beneficiaries Medigap policies A through J as required by the Medicare reform provisions under OBRA 1990, and the prior NAIC Model Regulation. Illinois will have to amend its regulations to create new Medigap plans K and L, and to eliminate prescription drug coverage under its standard H, I and J Medigap policies for those who enroll in Medicare Part D. It

also will have to amend its regulations to include the prohibitions and other changes under MMA.

Minnesota: Minnesota, like Wisconsin, received a waiver from the federal standardization regulations. Minnesota makes available to its Medicare beneficiaries two standardized policies (basic and extended basic), both of which may include optional riders to cover prescription drugs. Minnesota will have to amend its Medicare supplement regulations to create two cost-sharing plans, and eliminate the optional riders that cover prescription drugs. It also will have to amend its regulations to include the prohibitions and other changes under MMA.

Michigan: Michigan makes available to its Medicare beneficiaries Medigap policies A through J as required by the Medicare reform provisions under OBRA 1990, and the prior NAIC Model Regulation. Michigan will have to amend its regulations to create new Medigap plans K and L, and to eliminate prescription drug coverage under its standard H, I and J Medigap policies for those who enroll in Medicare Part D. It also will have to amend its regulations to include the prohibitions and other changes under MMA.

8. A summary of the factual data and analytical methodologies that OCI used in support of the proposed rule and how any related findings support the regulatory approach chosen for the proposed rule:

CMS data indicates that Medicare currently covers 40 million Americans, 806,000 of whom are Wisconsin residents. An estimated 27 percent of Medicare beneficiaries are covered by Medigap policies.

Information collected by the OCI indicates that 40 insurance companies offer Medicare supplement, Medicare cost and Medicare select (Medigap) policies to Wisconsin consumers

eligible for Medicare due to age or disability. In addition, there are 25 insurance companies that have Medigap policyholders although the companies no longer market Medigap coverage in Wisconsin. At year end 2003, there were 308,875 Wisconsin Medicare beneficiaries with Medigap policies. The majority of these Wisconsin Medicare beneficiaries have Medigap policies that will be affected by the Medigap reforms under the MMA.

A 2000 report by CMS, Office of Research, Development, and Information, based on 1999 Medicare data indicates that Medicare paid 53% of the health care expenses of persons 65 or over, and private health insurance, including Medicare supplement policies paid 12% of these health care expenses. The report indicated that overall annual medical expenses per Medicare beneficiaries equaled $9,573.

9. Any analysis and supporting documentation that OCI used in support of OCI's determination of the rule's effect on small businesses under s. 227.114:

OCI reviewed financial statements and other reports filed by life, accident and health insurers and determined that none qualifies as a small business. Wisconsin currently has 40 insurance companies offering Medicare supplement, Medicare cost and Medicare select insurance plans. None of these insurers meet the definition of a small business under s. 227.114, Wis. Stats.

10. If these changes may have a significant fiscal effect on the private sector, the anticipated costs that will be incurred by private sector in complying with the rule:

The proposed rule will not significantly impact the private sector. Insurers offering Medigap policies (Medicare supplement, Medicare cost, and Medicare select policies) will incur costs associated with developing new Medigap policies and marketing materials, mailing riders and explanatory materials to existing policyholders and reprogramming claim processing systems. However, these costs are offset by the insurers' ability to continue offering Medigap policies to Wisconsin consumers.

The MMA prohibits insurance companies and insurance agents from marketing in Wisconsin current Medigap policies after December 31, 2005. Failure to amend s. Ins 3.39, Wis. Adm. Code, will mean that Wisconsin Medicare beneficiaries will not have access to coverage that supplements Medicare benefits.

11. A description of the Effect on Small Business:

This rule does not have a significant impact on regulated small businesses as defined in s. 227.114 (1), Wis. Stat. OCI maintains a database of all licensed insurers in Wisconsin. The database includes information submitted by the companies related to premium revenue and employment. In an examination of this database, OCI identified that 40 insurance companies offer Medicare supplement, Medicare cost and Medicare select (Medigap) policies to Wisconsin consumers eligible for Medicare due to age or disability and none of those companies qualify by definition as a small business. In addition, there are 25 insurance companies that have Medigap policyholders although the companies no longer market Medigap coverage in Wisconsin. Again, none of these 25 companies qualifies by definition as a small business.

12. Agency contact person:

A copy of the full text of the proposed rule changes, analysis and fiscal estimate may be obtained from the WEB sites at: **http://oci.wi.gov/ocirules.htm** or by contacting Inger Williams, OCI Services Section, at:

Phone: (608) 264-8110
Email: Inger.Williams@oci.state.wi.us
Address: 125 South Webster St – 2nd Floor Madison WI 53702
Mail: PO Box 7873, Madison WI 53707-7873

13. Place where comments are to be submitted and deadline for submission:

The deadline for submitting comments is 4:00 p.m. on the 14th day after the date for the hearing stated in the Notice of Hearing.

Mailing address:

Julie E. Walsh
Legal Unit - OCI Rule Comment for Rule Ins 339
Office of the Commissioner of Insurance
PO Box 7873

Madison WI 53707-7873

Street address:

Julie E. Walsh
Legal Unit - OCI Rule Comment for Rule Ins 339
Office of the Commissioner of Insurance
125 South Webster St – 2nd Floor
Madison WI 53702

WEB Site: **http://oci.wi.gov/ocirules.htm**

The proposed rule changes are:

SECTION 1. Section Ins 3.39 (1) (c) is amended to read:

Ins 3.39 (1) (c) Wisconsin statutes interpreted and implemented by this rule are ss. 185.983 (1m), 600.03, 601.01 (2), 609.01 (~~2~~1g) (b), 625.16, 628.34 (12), 628.38, 631.20 (2), 632.73 (2m), 632.76 (2) (b) and 632.81, 632.895 (6) and (9), Stats.

SECTION 2. Section Ins 3.39 (2) (f) is created to read:

Ins 3.39 (2) (f) This section may be enforced under ss. 601.41, 601.64, 601.65, Stats., or ch. 645, Stats., or any other enforcement provision of chs. 600 to 646, Stats., or Wisconsin Administrative Code Insurance chapters.

SECTION 3. Section Ins 3.39 (3) is repealed and recreated to read:

Ins 3.39 (3) DEFINITIONS. In this section and for use in policies or certificates:

(a) "Accident," "Accidental Injury" or "Accidental Means" shall be defined to employ "result" language and shall not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

1. The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided" means accidental bodily injury sustained by the insured person that

is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

2. The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law or motor vehicle no-fault plan, unless prohibited by law.

(b) "Advertisement" has the meaning set forth in s. Ins 3.27 (5) (a).

(c) "Applicant" means:

1. In the case of an individual Medicare supplement or Medicare replacement policy, the person who seeks to contract for insurance benefits.

2. In the case of a group Medicare supplement policy, the proposed certificateholder.

(d) "Benefit period," or "Medicare benefit period" shall not be defined more restrictively than as defined in the Medicare program.

(e) "CMS" means the Centers for Medicare & Medicaid Services.

(f) "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

(g) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(h) "Continuous period of creditable coverage" means 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.

(i) 1. "Creditable coverage" means with respect to an individual, coverage of the individual provided under any of the following:

a. A group health plan;

b. Health insurance coverage;

c. Part A or Part B of Title XVIII of the Social Security Act (Medicare);

d. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928;

e. Chapter 55 of Title 10 United States Code, commonly referred to as TRICARE (formerly known as CHAMPUS);

f. A medical care program of the Indian Health Service or of a tribal organization;

g. A state health benefits risk pool;

h. A health plan offered under chapter 89 of Title 5 United States Code commonly referred to as the Federal Employees Health Benefits Program;

i. A public health plan as defined in federal regulation; and

j. A health benefit plan under Section 5 (e) of the Peace Corps Act (22 United States Code 2504 (e)).

2. “Creditable coverage” does not include any of the following:

a. Coverage only for accident or disability income insurance, or any combination thereof;

b. Coverage issued as a supplement to liability insurance;

c. Liability insurance, including general liability insurance and automobile liability insurance;

d. Worker’s compensation or similar insurance;

e. Automobile medical payment insurance;

f. Credit-only insurance;

g. Coverage for on-site medical clinics; and

h. Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

3. “Creditable coverage” shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

a. Limited scope dental or vision benefits;

b. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination; and

c. Such other similar, limited benefits as are specified in federal regulations.

4. “Creditable coverage” shall not include the following benefits if offered as independent, non-coordinated benefits:

a. Coverage only for a specified disease or illness; and

b. Hospital indemnity or other fixed indemnity insurance.

5. “Creditable coverage” shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

a. Medicare supplemental health insurance as defined under section 1882(g) (1) of the Social Security Act;

b. Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code; and

c. Similar supplemental coverage provided to coverage under a group health plan.

(j) “Employee welfare benefit plan” means a plan, fund or program of employee benefits as defined in 29 U.S.C. 1002 (Employee Retirement Income Security Act).

(k) "Health care expense" means, for purposes of sub. (16), expense of health maintenance organizations associated with the delivery of health care services that are analogous to incurred losses of insurers.

(L) "Health maintenance organization (HMO)" means an insurer as defined in s. 609.01 (2), Stats.

(m) "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare program.

(n) "Hospital confinement indemnity coverage" means coverage as defined in s. Ins 3.27 (4) (b) 6.

(o) "Insolvency" is defined in s. 600.03 (24), Stats., and means when an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it by a court of competent jurisdiction in the issuer's state of domicile.

(p) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

(q) "Medicare" shall be defined in the policy. "Medicare" may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

(r) "Medicare Advantage plan" means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28 (b) (1), as amended, and includes any of the following:

1. Coordinated care plans that provide health care services, including but not limited to health maintenance organization plans (with or without point-of-service option), plans offered by provider-sponsored organizations, and preferred provider plans;

2. Medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account; and

3. Medicare Advantage private fee-for-service plans.

(s) "Medicare eligible expenses" means health care expenses that are covered by Medicare Parts A and B, recognized as medically necessary and reasonable by Medicare, and that may or may not be fully reimbursed by Medicare.

(t) "Medicare eligible person" mean a person who qualifies for Medicare.

(u) "MMA" means the Medicare Prescription Drugs, Improvement and Modernization Act of 2003, Public Law 108-173, signed into law on December 8, 2003.

(v) "Medicare replacement coverage" means coverage that meets the definition in s. 600.03 (28p), Stats., as interpreted by sub. (2) (a), and that conforms to subs. (4) and (7). "Medicare replacement coverage" includes Medicare cost and Medicare Advantage plans.

(w) "Medicare supplement coverage" means coverage that meets the definition ins. 600.03 (28r), Stats., as interpreted by sub. (2) (a) and that conforms to subs. (4), (5), (6) and (30). "Medicare supplement coverage" includes Medicare supplement and Medicare select plans but does not include coverage under Medicare Advantage plans established under Medicare Part C or Outpatient Prescription Drug plans established under Medicare Part D.

(x) "Nursing home coverage" means coverage for care that is convalescent or custodial care or care for a chronic condition or terminal illness and provided in an institutional or community-based setting.

(y) "Outline of coverage" means a printed statement as defined by s. Ins 3.27 (5) (L), which meets the requirements of sub. (4) (b).

(z) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

(aa) "PACE" means Program of All–Inclusive Care for the Elderly (PACE) under section 1894 of the Social Security Act 42 U.S.C. 1302 and 1395.

(bb) "Replacement" means any transaction, other than when used to refer to an authorized Medicare Advantage policy, wherein new Medicare supplement or Medicare cost insurance is to be purchased, and it is known to the agent or issuer at the time of application that, as part of the transaction, existing accident and sickness insurance has been or is to be lapsed, cancelled or terminated or the benefits thereof substantially reduced.

(cc) "Secretary" means the secretary of the United States department of health and human services.

(dd) 1. "Sickness" shall not be defined to be more restrictive than illness or disease of an insured person that first manifests itself after the effective date of insurance and while the insurance is in force.

2. The definition of "sickness" may be further modified to exclude any illness or disease for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

(ee) "Specified disease coverage" means coverage that is limited to named or defined sickness conditions. The term does not include dental or vision care coverage.

SECTION 4. Sections Ins 3.39 (4) (intro.), (4) (a) 1., 2., 3., 6., 12., 18m. and 18r. b are amended to read:

Ins 3.39 (4) (intro.) MEDICARE SUPPLEMENT AND MEDICARE REPLACEMENT POLICY AND CERTIFICATE REQUIREMENTS. Except as explicitly allowed by subs. (5), (7) and (30), no disability insurance policy or certificate shall relate its coverage to Medicare or be structured, advertised ~~or~~, marketed or issued for delivery in this state as a Medicare supplement or as a Medicare replacement policy, as defined in s. 600.03 (28p) (a) and (c), and (28r), Stats., unless:

(a) 1. Provides only the coverage set out in sub. (5), (7) or (30) and applicable statues and contains no exclusions or limitations other than those permitted by sub. (8). ~~After being notified by the commissioner in writing that the federal department of health and human services has approved the Wisconsin Medicare supplement regulatory program including the Medicare Select~~select ~~program in sub. (30), no an HMO Medicare supplement policy under sub. (5) and all HMO Medicare supplement policies must be written in accordance with sub. (30)~~No issuer may issue a Medicare cost or Medicare select policy without prior approval from the commissioner and compliance with subs. (7) and (30), respectively.

2. Discloses on the first page any applicable pre-existing condition limitations, contains no pre-existing condition waiting period longer than 6 months and ~~does~~shall not define a pre-existing condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage~~;~~.

3. Contains no definitions of terms such as “Medicare eligible expenses,” “accident,” “sickness,” “mental or nervous disorders,” “skilled nursing facility,” “hospital,” “nurse,” “physician,” “Medicare approved expenses,” ‘benefit period,” “convalescent nursing home,” or “outpatient prescription drugs” ~~which~~that are worded less favorably to the insured person than

the corresponding Medicare definition or the definitions contained in sub. (3), and defines "Medicare" as in accordance with sub. (3) (~~c~~p)~~;~~.

6. Provides that termination of ~~the~~a Medicare supplement or Medicare cost policy or certificate shall be without prejudice to a continuous loss ~~which~~that commenced while the policy or certificate was in force, although the extension of benefits may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits~~;~~. Receipt of Medicare Part D benefits shall not be considered in determining a continuous loss.

12. Contains a provision describing the review and appeal procedure for denied claims required by s. 632.84, Stats.~~;~~, and a provision describing any grievance rights required by s. 632.83, Stats., applicable to Medicare supplement and Medicare replacement policies; and

18m. If the suspension in par. (18) occurs and if the policyholder or certificateholder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted (effective as of the date of termination of the entitlement) as of the termination of entitlement if the policyholder or certificateholder provides notice of loss of entitlement within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of the entitlement.

18r. b Shall provide for resumption of coverage ~~which is substantially equivalent to coverage~~that was in effect before the date of ~~such~~ suspension~~;~~ in subd. (18). If the suspended Medicare supplement or Medicare cost policy provided coverage for outpatient prescription drugs, reinstitution of the policy shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

SECTION 5. Section Ins 3.39 (4) (a) 20. and 21. are created to read:

Ins 3.39 (4) (a) 20. a. A policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006, shall be renewed for current policyholders who do not enroll in Medicare Part D at the option of the policyholder.

b. A policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

c. After December 31, 2005, a policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part D unless the policy is modified to eliminate outpatient prescription drug coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Medicare Part D plan and the premiums are adjusted appropriately to reflect elimination of that coverage.

21. If a policy that provides Medicare supplement or Medicare cost coverage eliminates an outpatient prescription drug benefit as a result of requirements imposed by the MMA, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of subd. 5. of this subsection.

SECTION 6. Section Ins 3.39 (4m) (a), (b) and (d) are amended to read:

Ins 3.39 (4m) (a) ~~Unless the coverage is subject to sub. (7), an~~An issuer may not deny or condition the issuance or effectiveness of, or discriminate in the pricing of, basic Medicare supplement coverage, Medicare cost or Medicare ~~Select~~select policies permitted under subs. (5), (7) and (30) or riders permitted under sub. (5) (i) for which an application is submitted prior to or during the 6-month period beginning with the first month in which an individual first enrolled for benefits under Medicare Part B or the month in which an individual turns age 65 for any individual who was first enrolled in Medicare Part B when under the age of 65 on any of the following grounds:

(b) ~~This~~ Except as provided in pars. (c) and (d) and sub. (34), this section shall not prevent the application of any ~~preexisting~~pre-existing condition limitation ~~which~~that is in compliance with sub. (4) (a) 2.

(d) If the applicant qualifies under par. (a) and submits an application during the time period referenced in par. (a) and, as of the date of application, has had a continuous period of creditable coverage that is less than 6 months, the issuer shall reduce the period of any ~~preexisting~~pre-existing condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The ~~secretary~~Secretary shall specify the manner of the reduction in this paragraph.

SECTION 7. Sections Ins 3.39 (5) (c) 6., 12., 13., 14., and 15., (i) (intro.) and 7., (j), (k) (intro.), (m) (intro.) are amended to read:

Ins 3.39 (5) (c) 6. ~~Nursing home confinement~~ Skilled nursing care and kidney disease treatment as required under s. 632.895 (3) and (4), Stats.~~;~~ Coverage for skilled nursing care shall be in addition to the required coverage under sub. 2. and payment of the Medicare Part A copayment for Medicare eligible skilled nursing care shall not count as satisfying the coverage requirement of at least 30 days of non-Medicare eligible skilled nursing care under s. 632.895 (3), Stats.;

12. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of all Medicare Part A ~~eligible~~ expenses for hospitalization not covered by Medicare to the extent the hospital is permitted to charge by federal law and regulation and subject to the Medicare reimbursement rate;

13. ~~Payment~~Prior to January 1, 2006, payment in full for all usual and customary expenses for treatment of diabetes required by s. 632.895 (6), Stats. After December 31, 2005, payment in accordance with s. 632.895 (6), Stats., including non-prescription insulin or any other non-prescription equipment and supplies for the treatment of diabetes, but not including

any other outpatient prescription medications. Issuers are not required to duplicate expenses paid by Medicare.

14. Coverage for preventive health care services ~~such as routine physical examinations, immunizations, health screenings, and inhospital private duty nursing services,~~ not covered by Medicare and as determined to be medically appropriate by an attending physician. ~~If offered, these~~These benefits shall be included in the basic policy. Reimbursement shall be for the actual charges up to 100% of the Medicare approved amount for each service, as if Medicare were to cover the service, as identified in the American Medical Association Current Procedural Terminology (AMA CPT) codes, to a minimum of $120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

15. Coverage for at least 80% of the charges for outpatient prescription drugs after a drug deductible of no more than $6,250 per ~~calender~~calendar year. Subject to sub. (4) (a) 20., this coverage may only be included in a Medicare supplement policy issued before January 1, 2006.

(i) (intro.) Permissible additional coverage only added to the policy as separate riders. The issuer shall issue a separate rider for each coverage the issuer chooses to offer. ~~and each~~Issuers shall ensure that the riders offered are compliant with MMA, that each rider ~~shall be~~ is priced separately, available for purchase separately at any time, subject to underwriting and the ~~preexisting~~pre-existing limitation allowed in sub. (4) (a) 2., and may consist of the following:

(i) 7. At least 50% of the charges for outpatient prescription drugs after a deductible of no greater than $250 per year to a maximum of at least $3,000 in benefits received by the insured per year. The rider shall be designated as: **OUTPATIENT PRESCRIPTION DRUG RIDER**. This rider may only be offered for issuance or sale until January 1, 2006 in accordance with MMA.

(j) For HMO Medicare ~~Select~~select policies, only the benefits specified in sub. (30) (p), (r) and (~~q~~s), in addition to Medicare benefits.

(k) (intro.) For the ~~medicare~~Medicare supplement high deductible plan~~,~~ that may be issued only prior to December 31, 2005 or renewed thereafter in accordance with sub. (29) (b) 1., the following:

(m)(intro.) For the ~~medicare~~Medicare supplement high deductible drug plan~~,~~ that may be issued only prior to December 31, 2005 or renewed thereafter in accordance with sub. (4) (a) 20., the following:

SECTION 8. Section Ins 3.39 (5) (n) and (o) are created to read:

Ins 3.39 (5) (n) For the Medicare Supplement 50% Cost-Sharing plans, only the following:

1. The designation: **MEDICARE SUPPLEMENT 50% COST-SHARING PLAN**;

2. Coverage of 100% of the Medicare Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

3. Coverage for 100% of the Medicare Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

4. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system rate, or other appropriate Medicare standard of payment, subject to a lifetime limitation benefit of an additional 365 days;

5. Medicare Part A Deductible: Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subd. 12;

6. Skilled Nursing Facility Care: Coverage for 50% of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subd. 12.;

7. Hospice Care: Coverage for 50% of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subd. 12.;

8. Coverage for 50%, under Medicare Part A or B, of the reasonable cost of the first 3 pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subd. 12.;

9. Except for coverage provided in subd. 11., coverage for 50% of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Medicare Part B deductible until the out-of-pocket limitation is met as described under subd. 12.;

10. Coverage of 100% of the cost sharing for the benefits described in pars. (c) 1., 5., 6., 8., 13., 16., and 17., and (i) 2., to the extent the benefits do not duplicate benefits paid by Medicare and after the policyholder pays the Medicare Part A and Part B deductible and meets the out-of-pocket limitation described under subd. 12.;

11. Coverage of 100% of the cost sharing for Medicare Part B preventive services after the policyholder pays the Medicare B deductible; and

12. Coverage of 100% of all cost sharing under Medicare Part A or B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary.

(o) For the Medicare Supplement 25% Cost-Sharing plans, only the following:

1. The designation: **MEDICARE SUPPLEMENT 25% COST-SHARING PLAN**;

2. Coverage of 100% of the Medicare Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

3. Coverage for 100% of the Medicare Part A hospital co-insurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

4. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system rate, or other appropriate Medicare standard of payment, subject to a lifetime limitation benefit of an additional 365 days;

5. Medicare Part A Deductible: Coverage for 75% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subd. 12.;

6. Skilled Nursing Facility Care: Coverage for 75% of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subd. 12.;

7. Hospice Care: Coverage for 75% of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subd. 12.;

8. Coverage of 75%, under Medicare Part A or B, of the reasonable cost of the first 3 pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subd. 12.;

9. Except for coverage provided in subd. 11., coverage for 75% of the cost sharing otherwise applicable under Medicare Part B, after the policyholder pays the Medicare Part B deductible until the out-of-pocket limitation is met as described in subd. 12.;

10. Coverage of 100% of the cost sharing for the benefits described in pars. (c) 1., 5., 6., 8., 13., 16., and 17., and (i) 2., to the extent the benefits do not duplicate benefits paid by Medicare and after the policyholder pays the Medicare Part A and Part B deductible and meets the out-of-pocket limitation described under subd. 12.;

11. Coverage for 100% of the cost sharing for Medicare Part B preventive services after the policyholder pays the Medicare Part B deductible; and

12. Coverage for 100% of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $2,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary.

SECTION 9. Sections Ins 3.39 (7) is repealed and recreated to read:

Ins 3.39 (7) AUTHORIZED MEDICARE REPLACEMENT POLICY AND CERTIFICATE DESIGNATION, CAPTIONS AND REQUIRED MINIMUM COVERAGES. (a) A Medicare cost policy or certificate issued by an issuer that has a cost contract with CMS for Medicare benefits shall meet the standards and requirements of subs. (4) and shall contain all of the following required coverages, to be referred to as "Basic Medicare cost coverage" for a policy issued after January 1, 2005;

1. The designation: **MEDICARE COST INSURANCE**;

2. The caption, except that the word "certificate" may be used instead of "policy," if appropriate: "The Wisconsin Insurance Commissioner has set minimum standards for Medicare cost insurance. This policy meets these standards. For an explanation of these standards and other important information, see 'Wisconsin Guide to health Insurance for People with

Medicare,' given to you when you bought this policy. Do not buy this policy if you did not get this guide;"

3. Upon exhaustion of Medicare hospital inpatient psychiatric coverage, at least 175 days per lifetime for inpatient psychiatric hospital care;

4. Medicare Part A eligible expenses in a skilled nursing facility for the copayments for the 21st through the 100th day;

5. All Medicare Part A eligible expenses for blood to the extent not covered by Medicare;

6. All Medicare Part B eligible expenses to the extent not paid by Medicare, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, including outpatient psychiatric care, subject to Medicare Part B calendar year deductible;

7. Coverage for the first three pints of blood payable under Medicare Part B;

8. Coverage of Medicare Part A eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

9. Coverage of Medicare Part A eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

10. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of all Medicare Part A expenses for hospitalization not covered by Medicare and to the extent the hospital is permitted to charge by federal law and regulation or at the Medicare reimbursement rate; and

11. Coverage for preventive health care services not covered by Medicare and as determined to be medically appropriate by an attending physician. If offered, these benefits shall be included in the basic policy. Reimbursement shall be for the actual charges up to 100%

of the Medicare approved amount for each service, as if Medicare were to cover the service, as identified in the American Medical Association Current Procedural Terminology (AMA CPT) codes, to a minimum of $120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

(b) Medicare replacement policies, as defined in s. 600.03 (28p) (a) and (c), Stats., are exempt from the provisions of s. 632.73 (2m), Stats., and are subject to the following:

1. Medicare replacement policies shall permit members to disenroll at any time for any reason. Premiums paid for any period of the policy beyond the date of disenrollment shall be refunded to the member on a pro rata basis. A Medicare replacement policy shall include a written provision providing for the right to disenrolls which shall contain all of the following:

a. Be printed on, or attached to, the first page of the policy.

b. Have the following caption or title: **"RIGHT TO DISENROLL FROM PLAN."**

c. Include the following language or substantially similar language approved by the commissioner. "You may disenrolls form the plan at any time for any reason. However, it may take up to 60 days to return you to the regular Medicare program. Your disenrollment will become effective on the day you return to regular Medicare. You will be notified by the plan of the date on which your disenrollment becomes effective. The plan will return any unused premium to you on a pro rata basis."

2. The Medicare replacement policy may require requests for disenrollment to be in writing. Enrollees may not be required to give their reasons for disenrolling, or to consult with an agent or other representative of the issuer before disenrolling.

(c) Each Medicare cost issuer, as defined in s. 600.03 (28p) (a) and (c), Stats., may offer an enhanced Medicare cost plan that contain the coverage contained in subs. (5) (c) 5., 6.,

7., 8., 13., 15., 16., 17., and the riders described in sub. (5) (i) and other coverages as authorized by CMS.

(d) In addition to all other subsections that are applicable to Medicare cost policies, the marketing of Medicare cost policies shall comply with the requirements of Medicare supplement policies contained in subs. (15), (21), (24), and (25). The outline of coverage listed in Appendix 1 and the replacement form specified in Appendix 5 shall be modified to accurately reflect the benefit, exclusions and other requirements that differ from Medicare supplement policies approved under sub. (5).

SECTION 10. Sections Ins 3.39 (14) (a), (c) 6., (j) and (m) are amended to read:

Ins 3.39 (14) (a) Each issuer may file and utilize only one individual Medicare supplement policy form, one individual Medicare select policy form, one individual Medicare replacement form and one group Medicare supplement policy form with any of the accompanying riders permitted in sub. (5) (i), unless the commissioner approves the use of additional forms and the issuer agrees to aggregate experience for the various forms in calculating rates and loss ratios.

(c) 6. Providing to the ~~U.S. secretary~~Secretary ~~of health and human services~~, at least annually, a central mailing address to which all claims may be sent by Medicare carriers; and

(j) Notwithstanding par. (a), an issuer may file and use only one individual Medicare ~~Select~~select policy form and one group Medicare ~~Select~~select policy form. These policy forms shall not be aggregated with non-Medicare ~~Select~~select forms in calculating premium rates, loss ratios and premium refunds.

(m) If Medicare determines the eligibility of a covered service, then the issuer ~~must~~shall use Medicare's determination in processing claims.

SECTION 11. Section Ins 3.39 (15) is amended to read:

Ins 3.39 (15) FILING REQUIREMENTS FOR ADVERTISING. Prior to use in this state, every issuer shall file with the commissioner a copy of any advertisement used in connections with the sale of Medicare supplement or Medicare cost policies issued with an effective date after December 31, 1989. If the advertisement does not reference a particular issuer or Medicare supplement or Medicare cost policy, each agent utilizing the advertisement shall file the advertisement with the commissioner prior to using it. Issuers and agents shall submit the advertisement using forms specified in Appendices 2 and 3. The advertisements shall comply with all applicable laws and rules for this state.

SECTION 12. Section Ins 3.39 (16) (a), (c) (intro.), 1., and 3., and (e) are amended to read:

Ins 3.39 (16) LOSS RATIO REQUIREMENTS AND RATES FOR EXISTING POLICIES. (a) Every issuer providing Medicare supplement or Medicare cost coverage on a group or individual basis on policies or certificates issued before on after August 1, 1992 in this state shall file annually its ratios of incurred losses or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis to earned premiums by policy duration for approval by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of par. (d) when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

(c) As soon as practicable, but no later October 1 of the year prior to the effective date of enhancements in Medicare benefits, every issuer providing Medicare supplement or Medicare cost policies or certificates in this state shall file with the commissioner in accordance with the applicable filing procedures of this state appropriate premium adjustments necessary to

produce loss ratios as originally anticipated for the current premium for the applicable policies or certificates. Supporting documents as necessary to justify the adjustment shall accompany the filing.

1. Every issuer shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or certificate as will conform with minimum loss ratio standards for Medicare supplement or Medicare cost policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for such Medicare supplement or Medicare cost insurance policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein should be made with respect to a policy at any time other than upon its renewal date or anniversary date.

3. An issuer shall file any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement or Medicare cost policy or certificate modifications necessary to eliminate benefit duplications with Medicare. Such riders, endorsements or policy forms shall provide a clear description of the Medicare supplement or Medicare cost benefits provided ~~provided~~ by the policy or certificate.

(e) An issuer may not use or change any premium rates for an individual or group Medicare supplement or Medicare cost policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner and in accordance with sub. (4) (g).

SECTION 13. Section Ins 3.39 (21) (a) and (e) are amended to read:

Ins 3.39 (21) COMMISSION LIMITATIONS. (a) An issuer may provide and an agent or other representative may accept commission or other compensation for the sale of a Medicare supplement or Medicare cost policy or certificate only if the first year commission or other first

year compensation is at least 100% and no more than 150% of the commission or other compensation paid for selling or servicing the policy or certificate in the 2nd year.

(e) No issuer may provide an agent or other representative commission or compensation for the sale of a Medicare supplement or Medicare cost policy or certificate to an individual who is under age 66 which is either calculated on a different basis or is less than the average of the commissions paid for the sale of a Medicare supplement or Medicare cost policy or certificate to an individual who is age 65 to age 69.

SECTION 14. Section Ins 3.39 (22) (a), (b), (d), (e), (f) (intro.) and 1. are amended to read:

Ins 3.39 (22) REQUIRED DISCLOSURE PROVISIONS. (a) Medicare supplement and Medicare cost policies and certificates shall include a renewal or continuation provision. The language or specifications of such provision must be consistent with the type of contract issued. Such provision shall be appropriately captioned and shall appear on the first page of the policy and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

(b) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement or Medicare cost policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits; all riders or endorsements added to a Medicare supplement or Medicare cost policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits of coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement or Medicare cost insurance policies, or if the increased benefits or coverage is

required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

(d) If a Medicare supplement or Medicare cost policy or certificate contains any limitations with respect to pre-existing conditions, such limitations shall appear on the first page.

(e) Medicare supplement or Medicare cost policies and certificates shall have a notice prominently printed on the first page of the policy and certificate or attached thereto stating in substance that the policyholder or certifcateholder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded, if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

(f) (intro.) As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders~~, contractholders~~ and certificateholders of modifications it has made to Medicare supplement or Medicare cost insurance policies or certificates in the form similar to Appendix 4. The notice shall:

1. Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement or Medicare cost policy or certificate, and

SECTION 15. Section Ins 3.39 (22) (i) is repealed and recreated to read:

Ins 3.39 (22) (i) Issuers shall comply with any notice requirements of the MMA.

SECTION 16. Section Ins 3.39 (23) (a) (intro.), 1., 3., and 4., and (c) are amended to read:

Ins 3.39 (23) REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE. (a) (intro.) Application forms for Medicare supplement and Medicare cost coverage shall comply with all relevant statutes and rules. The application form, or a supplementary form signed by the applicant and agent, shall include the following statements and questions:

[Statements]

1. You do not need more than one Medicare supplement, Medicare cost or Medicare select policy.

3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement, Medicare cost or Medicare select policy.

4. ~~The~~If after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement, Medicare cost or Medicare select policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement, Medicare cost or Medicare select policy, or, if that is no longer available, a substantially equivalent policy, will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement, Medicare cost or Medicare select policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

(c) Upon determining that a sale will involve replacement, an issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement or Medicare cost policy or certificate, a notice regarding replacement of accident and sickness coverage in no less than 12 point type. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the solicitation of the policy the notice regarding replacement of accident and sickness coverage.

SECTION 17. Section Ins 3.39 (23) (a) 5. is renumbered to 6. and amended to read:

Ins 3.39 (23) (a) ~~5~~6. Counseling services may be available in your state or provide advice concerning your purchase of ~~medicare~~Medicare supplement or Medicare cost insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). See the booklet *"Wisconsin Guide to Health Insurance for People with Medicare,"* which you received at the time you were solicited to purchase this policy.

[Questions]

~~1. Do you have another Medicare supplement policy or certificate in force?~~

~~a. If so, with which company?~~

~~b. If so, do you intend to replace your current Medicare supplement policy with this policy certificate?~~

~~2. Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement policy?~~

~~a. If so, with which company?~~

~~b. What kind of policy?~~

~~3. Are you covered for medical assistance through the state Medicaid program:~~

~~a. As a Specified low-Income Medicare Beneficiary (SLMB)?~~

~~b. As a Qualified Medicare Beneficiary (QMB)?~~

~~c. For other Medicaid medical benefits?~~

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

[Please mark Yes or No below with an "X"]

To the best of your knowledge,

1. a. Did you turn age 65 in the last 6 months?

Yes No

b. Did you enroll in Medicare Part B in the last 6 months?

Yes No

c. If yes, what is the effective date? _____

2. Are you covered for medical assistance through the state Medicaid program?

Yes No

[NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.]

If yes,

a. Will Medicaid pay your premiums for this Medicare supplement policy?

Yes No

b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

Yes No

3. a. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare health maintenance organization or preferred provider organization), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START ___/___/___ END ___/___/___

b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

Yes No

c. Was this your first time in this type of Medicare plan?

Yes No

d. Did you drop a Medicare supplement policy to enroll in the Medicare plan?

Yes No

4. a. Do you have another Medicare supplement policy in force?

Yes No

b. If so, with what company, and what plan do you have [optional for Direct Mailers]?

_____

c. If so, do you intend to replace your current Medicare supplement policy with this policy?

Yes No

5. Have you had coverage under any other health insurance within the past 63 days? (For example an employer, union, or individual plan)

Yes No

a. If so, with what company and what kind of policy?

_____

_____

_____

_____

b. What are your dates of coverage under the other policy?

START / / END / /

(If you are still covered under the other policy, leave "END" blank.)

SECTION 18. Section Ins 3.39 (23) (a) 5. is created to read:

Ins 3.39 (23) (a) 5. If you are eligible for and have enrolled in a Medicare supplement or Medicare cost policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement or Medicare cost policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement or Medicare cost policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement or Medicare cost policy or, if that is no longer available, a substantially equivalent policy will be reinstituted if requested within 90 days of

losing your employer or union-based group health plan. If the Medicare supplement or Medicare cost policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

SECTION 19. Section Ins 3.39 (25) (a), (b) and (c) are amended to read:

Ins 3.39 (25) (a) In recommending the purchase or replacement of any Medicare supplement or Medicare replacement policy or certificate, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(b) Any sale of a Medicare supplement or Medicare replacement ~~coverage~~policy or certificate ~~which~~that will provide an individual more than one Medicare supplement or Medicare replacement policy or certificate is prohibited.

(c) An agent shall forward each application taken for a Medicare supplement or Medicare replacement policy to the issuer within 7 calendar days after taking the application. An agent shall mail the portion of any premium collected due the issuer to the issuer within 7 days after receiving the premium.

SECTION 20. Section Ins 3.39 (26) and (27) are amended to read:

Ins 3.39 (26) REPORTING OF MULTIPLE POLICIES. (a) On or before March 1 of each year, every issuer providing Medicare supplement or Medicare cost insurance coverage in this state shall report the following information for every individual resident of this state for which the insurer has in force more than one Medicare supplement or Medicare cost insurance policy or certificate:

Ins 3.39 (27) WAITING PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES. If a Medicare supplement or Medicare cost policy or certificate replaces another Medicare supplement or Medicare cost policy or certificate, the replacing issuer shall waive any time

periods applicable to pre-existing condition waiting periods in the new Medicare supplement policy or new Medicare cost to the extent such time was satisfied under the original policy or certificate.

SECTION 21. Section Ins 3.39 (29) is amended to read:

Ins 3.39 (29) FILING AND APPROVAL REQUIREMENTS. (a) An issuer shall not deliver or ~~issuer~~issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate has been filed with and approved by the commissioner in accordance with filing requirements and procedures prescribed by the commissioner.

(b) (intro.) An issuer shall file with the commissioner any new riders or amendments to policy or certificate forms to delete coverage for outpatient prescription drugs as required by MMA.

1. Beginning January 1, 2007, issuers shall replace existing amended policies and riders for current and renewing enrollees with filed and approved policy or certificate forms that are compliant with the MMA. An issuer shall, beginning January 1, 2007, use filed and approved policy or certificate forms that are compliant with the MMA for all new business.

SECTION 22. Section Ins 3.39 (30) (a) 1. and 2., (b) 1. – 7., (c), (d), (e) (intro.), (f) 1., (g), (h), (i) (intro.), (i) 1. b, 3., 7., and 9., (j), (k), (L), (m) 1. and 2., (n) (intro.), (n) 1. and 2., (o), (p) (intro.) and 8., are amended to read:

Ins (30) (a) 1. This subsection shall apply to Medicare ~~Select~~select policies and certificates.

2. No policy or certificate may be advertised as a Medicare ~~Select~~select policy or certificate unless it meets the requirements of this section.

(b) For the purposes of this section:

1. "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare ~~Select~~select issuer or its network providers.

2. “Grievance” means dissatisfaction expressed in writing by an individual insured under a Medicare ~~Select~~select policy or certificate with the administration, claims practices or provision of services concerning a Medicare ~~Select~~select issuer or its network providers.

3. “Medicare ~~Select~~select issuer” means an issuer offering, or seeking to offer, a Medicare ~~Select~~select policy or certificate.

4. “Medicare ~~Select~~select policy” or “Medicare ~~Select~~select certificate” mean, respectively, a Medicare supplement policy or certificate that contains restricted network provisions.

5. “Network provider” means 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~~select policy.

6. “Restricted network provision” means any provision ~~which~~that conditions the payment of benefits, in whole or in part, on the use of network providers.

7. “Service area” means the geographic area approved by the commissioner within which an issuer is authorized to offer a Medicare ~~Select~~select policy.

(c) The commissioner may authorize an issuer to offer a Medicare ~~Select~~select policy or certificate, pursuant to this subsection and section 4358 of the Omnibus Budget Reconciliation Act ~~(OBRA)~~ of 1990, if the commissioner finds that the issuer has satisfied all of the requirements of this subsection.

(d) A Medicare ~~Select~~select issuer shall not issue a Medicare ~~Select~~select policy or certificate in this state until its plan of operation has been approved by the commissioner.

(e) (intro.) A Medicare ~~Select~~select issuer shall file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

1. e. In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting such providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare ~~Select~~select policy or certificate. This paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare ~~Select~~select policy or certificate.

(f) 1. A Medicare ~~Select~~select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing such changes. Such changes shall be considered approved by the commissioner after 30 days unless specifically disapproved.

(g) A Medicare ~~Select~~select policy or certificate shall not restrict payment for covered services provided by non–network providers if:

(h) A Medicare ~~Select~~select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

(i) (intro.) A Medicare ~~Select~~select issuer shall make full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare ~~Select~~select policy or certificate to each applicant. This disclosure shall include at least the following:

1. An outline of coverage in substantially the same format as Appendix 1 sufficient to permit the applicant to compare the coverage and premiums of the Medicare ~~Select~~select policy or certificate with:

b. Other Medicare ~~Select~~select policies or certificates.

3. A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in the Medicare Select

50% and 25% Coverage Cost-Sharing plans offered by the Medicare select issuer pursuant to sub. (5) (q) and (r).

7. A description of the Medicare ~~Select~~select issuer's quality assurance program and grievance procedure.

9. The caption, except that the word "certificate" may be used instead of "policy," if appropriate: "The Wisconsin Insurance Commissioner has set standards for Medicare ~~Select~~select policies. This policy meets these standards. It, along with Medicare, may not cover all of your medical costs. You should review carefully all policy limitations. For an explanation of these standards and other important information, see 'Wisconsin Guide to Health Insurance for People with Medicare,' given to you when you applied for this policy. Do not buy this policy if you did not get this guide."

(j) Prior to the sale of a Medicare ~~Select~~select policy or certificate, a Medicare ~~Select~~select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to par. (i) of this section and that the applicant understands the restrictions of the Medicare ~~Select~~select policy or certificate.

(k) A Medicare ~~Select~~select issuer shall have and use procedures for hearing complaints and resolving written grievances from its subscribers. Such procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

(L) At the time of initial purchase, a Medicare ~~Select~~select issuer shall make available to each applicant for a Medicare ~~Select~~select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

(m) 1. At the request of an individual insured under a Medicare ~~Select~~select policy or certificate, a Medicare ~~Select~~select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer, which has comparable or lesser benefits, and which does not contain a restricted network provision.

The issuer shall make such policies or certificates available without requiring evidence of insurability after the Medicare ~~Select~~select policy or certificate has been in force for 6 months.

2. For the purposes of subd. 1., a Medicare supplement policy or certificate ~~will~~shall be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare ~~Select~~select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, ~~coverage for prescription drugs,~~ coverage for at–home recovery services or coverage for Medicare Part B excess charges.

(n) (intro.) Medicare ~~Select~~select policies and certificates shall provide for continuation of coverage in the event the ~~U.S. secretary~~Secretary ~~of health and human services~~ determines that Medicare ~~Select~~select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare ~~Select~~select program to be reauthorized under law or its substantial amendment.

1. Each Medicare ~~Select~~select issuer shall make available to each individual insured under a Medicare ~~Select~~select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer, which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies and certificates available without requiring evidence of insurability.

2. For the purposes of subd. 1., a Medicare supplement policy or certificate ~~will~~shall be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare ~~Select~~select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, ~~coverage for prescription drugs,~~ coverage for at–home recovery services or coverage for Medicare Part B excess charges.

(o) A Medicare ~~Select~~select issuer shall comply with reasonable requests for data made by state or federal agencies, including the ~~United States department of health and human services~~CMS for the purpose of evaluating the Medicare ~~Select Program~~select program.

(p) (intro.) ~~A~~Except as provided in par. (q) or (r), a Medicare ~~Select~~select policy shall contain the following benefits:

8. Coverage for at least 80% of the charges for outpatient prescription drugs after a drug deductible of no more than $6,250 per calendar year. This coverage may only be included in a Medicare select policy issued before January 1, 2006.

SECTION 23. Section Ins 3.39 (30) (q) and (r) are renumbered (s) and (t) and as renumbered, are amended to read:

Ins 3.39 (30) (s) A Medicare ~~Select~~select policy may include permissible additional coverage as described in sub. (5) (i) 7. This rider, if offered, shall be added to the policy as a separate rider or amendment, shall be priced separately and available for purchase separately. Subject to sub. (4) (a) 20., this rider may be offered by issuance or sale until January 1, 2006.

(t) Insurers writing Medicare ~~Select~~select policies shall additionally comply with subchs. I and III of ch. Ins 9.

SECTION 24. Section Ins 3.39 (30) (q) and (r) are created to read:

Ins 3.39 (30) (q) The Medicare Select 50% Cost-Sharing plans shall only contain the following:

1. The designation: **MEDICARE SELECT 50% COST-SHARING PLAN**;

2. Coverage of 100% of the Medicare Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

3. Coverage for 100% of the Medicare Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

4. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system rate, or other appropriate Medicare standard of payment, subject to a lifetime limitation benefit of an additional 365 days;

5. Medicare Part A Deductible: Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subd. 12;

6. Skilled Nursing Facility Care: Coverage for 50% of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subd. 12;

7. Hospice Care: Coverage for 50% of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation is met as described in subd. 12.;

8. Coverage for 50%, under Medicare Part A or B, of the reasonable cost of the first 3 pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subd. 12.;

9. Except for coverage provided in subd. 11., coverage for 50% of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Medicare Part B deductible until the out-of-pocket limitation is met as described under subd. 12.;

10. Coverage of 100% of the cost sharing for the benefits described in pars. (c) 1., 5., 6., 8., 13., 16., and 17., and (i) 2., to the extent the benefits do not duplicate benefits paid by Medicare and after the policyholder pays the Medicare Part A and Part B deductible and meets the out-of-pocket limitation described under subd. 12.;

11. Coverage of 100% of the cost sharing for Medicare Part B preventive services after the policyholder pays the Medicare Part B deductible; and

12. Coverage of 100% of all cost sharing under Medicare Part A or B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary.

(r) The Medicare Select 25% Coverage Cost-Sharing plans shall only contain the following:

1. The designation: **MEDICARE SELECT 25% COST-SHARING PLAN**;

2. Coverage of 100% of the Medicare Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

3. Coverage for 100% of the Medicare Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

4. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system rate, or other appropriate Medicare standard of payment, subject to a lifetime limitation benefit of an additional 365 days;

5. Medicare Part A Deductible: Coverage for 75% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subd. 12.;

6. Skilled Nursing Facility Care: Coverage for 75% of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subd. 12.;

7. Hospice Care: Coverage for 75% of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation is met as described in subd. 12.;

8. Coverage for 75%, under Medicare Part A or B, of the reasonable cost of the first 3 pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subd. 12.;

9. Except for coverage provided in subd. 11., coverage for 75% of the cost sharing otherwise applicable under Medicare Part B, except there shall be no coverage for the Medicare Part B deductible until the out-of-pocket limitation is met as described in subd. 12;

10. Coverage of 100% of the cost sharing for the benefits described in pars. (c) 1., 5., 6., 8., 13., 16., and 17., and (i) 2., to the extent the benefits do not duplicate benefits paid by Medicare and after the policyholder pays the Medicare Part A and Part B deductible and meets the out-of-pocket limitation described under subd. 12.;

10. Coverage for 100% of the cost sharing for Medicare Part B preventive services after the policyholder pays the Medicare Part B deductible; and

11. Coverage for 100% of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $2,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary.

SECTION 25. Section Ins 3.39 (33) is repealed.

SECTION 26. Section Ins 3.39 (34) (a) (intro.), 1. and 2., (b) 1., 1m., 2. (intro.), 4. (intro.), 5. a., and 6. are amended to read:

Ins 3.39 (34) GUARANTEED ISSUE FOR ELIGIBLE PERSONS. (a) *Guaranteed issue*. 1. Eligible persons are those individuals described in par. (b) who seek to enroll under the policy during the period specified in par. (c), and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement <u>or Medicare cost</u> policy<u>, and where applicable, evidence of enrollment in Medicare Part D</u> ~~with the application for a Medicare supplement policy~~.

2. With respect to eligible person, an issuer may not deny or condition the issuance or effectiveness of a Medicare supplement or Medicare cost policy described in par. (e) that is offered and is available for issuance to new enrollees by the issuer, and shall not discriminate in the pricing of such a Medicare supplement or Medicare cost policy because of health status, claims experience, receipt of health care, or medical condition and shall not impose an exclusion of benefits based on condition and shall not impose an exclusion of benefits based on a ~~preexisting~~pre-existing condition under such a Medicare supplement or Medicare cost policy.

(b) 1. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under ~~medicare~~Medicare and the plan terminates, or the plan ceases to provide some or all such supplemental health benefits to the individual;

(b) 1m. The individual is enrolled under an employee welfare benefit plan that is primary to ~~medicare~~Medicare and the plan terminates or the plan ceases to provide some or all health benefits to the individual because the individual leaves the plan.

2. The individual is enrolled with a Medicare ~~+ Choice~~Advantage organization under a Medicare ~~+ Choice~~Advantage plan under Medicare ~~part~~Part C ~~of Medicare~~, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a PACE provider under section 1894 of the Social Security Act, and there are circumstances similar to those described in subd. 2. a. to e. that would permit discontinuance of the individual's enrollment and such provider if such individual were enrolled in a Medicare ~~+ Choice~~Advantage plan:

a. The certification of the organization or plan under ~~this~~ Medicare Part C ~~of Medicare~~ has been terminated; or

3. d. An organization under a Medicare ~~Select~~select policy; and

4. The individual is enrolled under a ~~medicare~~Medicare supplement policy and the enrollment ceases because:

5. a. The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare ~~+ Choice~~Advantage organization under a Medicare ~~+ Choice~~Advantage plan under ~~part~~ Medicare Part C ~~of Medicare~~, any eligible organization under a contract under section 1876 of the Social Security Act, Medicare cost, any similar organization operating demonstration project authority, any PACE provider under section 1894 of the Social Security Act, or a Medicare ~~Select~~select policy; and

6. The individual, upon first becoming eligible for benefits under Medicare ~~part~~Parts A and B ~~of Medicare~~ at age 65, enrolls in a Medicare ~~+ Choice~~Advantage plan under Medicare ~~part~~Part C ~~of Medicare~~, or with a PACE provider under section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than 12 months after the effective date of enrollment.

SECTION 27. Section Ins 3.39 (34) (b) 1r., 7. and 8. are created to read:

Ins 3.39 (34) (b) 1r. The individual is covered by an employee welfare benefit plan that is either primary to Medicare or provides health benefits that supplement the benefits of Medicare and the individual terminates coverage under the employee welfare benefit plan to enroll in a Medicare Advantage plan, but disenrolls from the Medicare Advantage plan by not later than 12 months after the effective date of enrollment.

7. The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Medicare Part D, was enrolled under a Medicare supplement, Medicare replacement, Medicare cost or Medicare select policy that covered outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement, Medicare replacement Medicare cost or Medicare select policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in par. (e) 4.

8. The individual is eligible for benefits under Medicare Parts A and B and is covered under the medical assistance program and subsequently loses eligibility in the medical assistance program.

SECTION 28. Section Ins 3.39 (34) (c) 1. (intro.), 1. a, 2. and 4., are amended to read:

Ins 3.39 (34) (c) 1. (intro.) In the case of an individual described in par. (b) 1. or 1m., the guaranteed issue period begins on the later of the following dates:

a. The date the individual receives a notice of termination or cessation of some or all supplemental health benefits, or, if a notice is not received, notice that a claim has been denied because of a termination or cessation, and ends 63 days after the date the applicable coverage is terminated.

2. In the case of an individual described in par. (b) 2., 3., 5., ~~or~~6. or 8., whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends on the date that is 63 days after the date such coverage is terminated.

4. In the case of an individual described in par. (b) 1r., 2., 4. b.~~, 4.~~ or c., 5., or 6. who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date.

SECTION 29. Section Ins 3.39 (34) (c) 5. is renumbered 6.

SECTION 30. Section Ins 3.39 (34) (c) 5. is created to read:

Ins 3.39 (34) (c) 5. In the case of an individual described in par. (b) 7., the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882 (v) (2) (B) of the Social Security Act from the Medicare supplement issuer during the 60-day period immediately preceding the initial Medicare Part D enrollment period and ends on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D.

SECTION 31. Sections Ins 3.39 (34) (e) and (f) are amended to read:

Ins 3.39 (34) (e) (intro.) *Products to which eligible persons are entitled.* The ~~medicare~~Medicare supplement or Medicare cost policy to which eligible persons are entitled under:

1. Paragraph (b) 1., 1m., 1r., 2., 3., and 4., is a Medicare supplement policy as defined in sub. (5) along with any riders available or a Medicare ~~Select~~select policy as defined in sub. (30)~~.~~ except the Outpatient Prescription Drug ~~rider~~Rider defined in sub. (5) (i) 7.

2. Paragraph (b) 5. is the same ~~medicare~~Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy as described in subd. 1.

3. Paragraph (b) 6. and 8. is a Medicare supplement policy as described in sub. (5) along with any riders available or a Medicare ~~Select~~select policy as defined in sub. (30).

4. Paragraph (b) 7., is a Medicare supplement policy as described in sub. (5) along with any riders available or a Medicare select policy as defined in sub. (30), that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with the outpatient prescription drug coverage.

5. Paragraph 3, is a Medicare cost policy as described in sub. (7) along with any enhancements and riders, that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare cost policy.

6. The Outpatient Prescription Drug Rider referenced in subd. 1., 1m., 1r., 2., 3., and 4. may only be issued through December 31, 2005.

(f) *Notification provisions.* 1. At the time of an event described in par. (b) because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the

issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of ~~medicare~~Medicare supplement or Medicare cost policies under par. (a). The notice shall be communicated contemporaneously with the notification of termination.

2. At the time of an event described in par. (b) because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of ~~medicare~~Medicare supplement or Medicare cost policies under par. (a). Such notice shall be communicated within ~~ten~~10 working days of the issuer receiving notification of disenrollment.

SECTION 32. Section Ins 3.39 Appendix 1 is repealed and recreated to read:

Ins 3.39 Appendix 1

The following information shall be inserted prior to each outline of coverage provided to an insured and include the information specific to the plan type.

PREMIUM INFORMATION

We can only raise your premium if we raise the premium for all policies like yours in this state. [Include information specifying when premiums will change.]

If your policy was issued as an under age 65 policy due to disability, when you turn 65 premiums will remain at the disabled rates. [Include this statement within premium information when issuer does not change premium to age 65 rate.]

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

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

POLICY REPLACEMENT

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

NOTICE

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

(1) The outline of coverage for a Medicare replacement insurance policy as defined in s. 600.03 (28p) a. and c., Stats., shall contain the following language: Medicare replacement insurance policy: This policy provides basic Medicare hospital and physician benefits. It also includes benefits beyond those provided by Medicare. This policy is a replacement for Medicare and is subject to certain limitations in choice of providers and area of service. The policy does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing, and taking medicine.

(2) (a) In 24–point type: For Medicare supplement policies marketed by intermediaries:

Neither (insert company's name) nor its agents are connected with Medicare.

(b) In 24–point type: For Medicare supplement policies marketed by direct response:

(insert company's name) is not connected with Medicare.

(c) For Medicare replacement policies as defined in s. 600.03 (28p) a. and c., Stats.:

(insert company's name) has contracted with Medicare to provide Medicare benefits. Except for emergency care anywhere or urgently needed care when you are temporarily out of the service area, all services, including all Medicare services, must be provided or authorized by (insert company's name).

(3) (a) For Medicare supplement policies, provide a brief summary of the major benefits and gaps in Medicare Parts A and B with a parallel description of supplemental benefits, including dollar amounts, as outlined in these charts.

(b) For Medicare replacement policies, as defined in s. 600.03 (28p) a. and c., Stats., provide a brief summary of both the basic Medicare benefits in the policy and additional benefits using the basic format as outlined in these charts and modified to accurately reflect the benefits.

(c) If the coverage is provided by a health maintenance organization as defined in s. 609.01 (2), Stats., provide a brief summary of the coverage for emergency care anywhere and urgent care received outside the service area if this care is treated differently than other covered benefits.

(4) If the plan is a Medicare Supplement High Deductible Plan as defined in sub. (5) (n) or (o), add the following text in a bold or contrasting color: You will pay [half (for plans defined in sub. (5) (n))] [one quarter (for plans defined in sub. (5) (o))] of the cost-sharing of some covered services until you reach the annual out-of-pocket maximum of [$4,000 (for plans defined in sub. (5) (n))] [$2,000 (for plan defined in sub. (5) (o))] each calendar year. The amounts you must pay are noted in the chart below. Once you reach the annual limit, the plan pays for 100% for the items or services noted in the chart.

The following information shall be inserted AFTER the specific plan type outline of coverage that is provided to all insureds. The information shall include the information specific to the plan type.

(5) All limitations and exclusions, including each of the following, must be listed under the caption "**LIMITATIONS AND EXCLUSIONS"** if benefits are not provided:

(a) Nursing home care costs beyond what is covered by Medicare and the additional 30–day skilled nursing mandated by s. 632.895 (3), Stats.

(b) Home health care above the number of visits covered by Medicare and the 365 visits mandated by s. 632.895 (2), Stats. [For Medicare select policies only.]

(c) Physician charges above Medicare's approved charge.

(d) Outpatient prescription drugs.

(e) Most care received outside of U.S.A.

(f) Dental care, dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for and the cost of eyeglasses or hearing aids, unless eligible under Medicare.

(g) Coverage for emergency care anywhere or for care received outside the service area if this care is treated differently than other covered benefits.

(h) Waiting period for pre–existing conditions.

(i) Limitations on the choice of providers or the geographical area served (if applicable for Medicare select policies only).

(j) Usual, customary, and reasonable limitations.

(6) CONSPICUOUS STATEMENTS AS FOLLOWS:
This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare & You" for more details.

(7) A description of policy provisions respecting renewability or continuation of coverage, including any reservation of rights to change premium.

(8) Information on how to file a claim for services received from non–participating providers because of an emergency within or outside of the service area shall be prominently disclosed.

(9) If there are restrictions on the choice of providers, a list of providers available to enrollees shall be included with the outline of coverage.

(10) A description of the review and appeal procedure for denied claims.

(11) The premium for the policy and riders, if any, in the following format:

MEDICARE SUPPLEMENT AND MEDICARE COST PREMIUM INFORMATION

Annual Premium

$ ( ) BASIC MEDICARE SUPPLEMENT OR MEDICARE COST COVERAGE

OPTIONAL BENEFITS FOR MEDICARE SUPPLEMENT OR MEDICARE COST POLICY

Each of these riders may be purchased separately.

(Note: Only optional coverages provided by rider shall be listed here.)

$ ( ) 1. Medicare Part A deductible

100% of Medicare Part A deductible

$ ( ) 2. Additional home health care

An aggregate of 365 visits per year including those covered by Medicare

$ ( ) 3. Medicare Part B deductible

100% of Medicare Part B deductible

$ ( ) 4. Medicare Part B excess charges

Difference between the Medicare eligible charge and the amount charged by the provider which shall be no greater than the actual charge or the limited charge allowed by Medicare, whichever is less

$ ( ) 5. Foreign travel rider

After a deductible not greater than $250, covers at least 80% of expenses associated with emergency medical care received outside the U.S.A. beginning the first 60 days of a trip with a lifetime maximum of at least $50,000

_____

$ ( ) TOTAL FOR BASIC POLICY AND SELECTED OPTIONAL BENEFITS

(Note: The soliciting agent shall enter the appropriate premium amounts and the total at the time this outline is given to the applicant. Medicare select policies and the Medicare Supplement 50% and 25% Cost-Sharing plans and Medicare Select 50% and 25% Cost-Sharing plans shall modify the outline to reflect the benefits that are contained in the policy and the optional or included riders.)

IN ADDITION TO THIS OUTLINE OF COVERAGE, [ISSUER] WILL SEND AN ANNUAL NOTICE TO YOU 30 DAYS PRIOR TO THE EFFECTIVE DATE OF MEDICARE CHANGES WITH WILL DESCRIBE THESE CHANGES AND THE CHANGES IN YOUR MEDICARE SUPPLEMENT COVERAGE.

(12) If premiums for each rating classification are not listed in the outline of coverage under subsection (11), then the issuer shall give a separate schedule of premiums for each rating classification with the outline of coverage.

(13) Include a summary of or reference to the coverage required by applicable statutes.

(14) The term “certificate” should be substituted for the word “policy” throughout the outline of coverage where appropriate.

Issuers shall select the appropriate outline of coverage specific to the plan being presented from among the following Outlines of Coverage A through D.

OUTLINE OF COVERAGE - A

(COMPANY NAME)

OUTLINE OF MEDICARE SUPPLEMENT INSURANCE

(The designation and caption required by sub. (4) (b) 4.)

MEDICARE SUPPLEMENT PART A – HOSPITAL SERVICES – PER BENEFIT PERIOD

Note: Issuers should include only the wording that applies to their policy's "This Policy Pays" column and complete the "You Pay" column.

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

Note: Add the following text in a bold or contrasting color if the policy is a Medicare Supplement High Deductible Plan as defined in sub. (5) (k) or (m), only until December 31, 2005: This high deductible plan pays the same as a non-high deductible plan after one has paid a calendar year [$] deductible. Benefits will not begin until out-of-pocket expenses are [$]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include [the plan's separate foreign travel emergency deductible.]

SERVICES	PER BENEFIT PERIOD	MEDICARE PAYS	[AFTER YOU PAY A $[ ] DEDUCTIBLE] THIS POLICY PAYS	YOU PAY
HOSPITALIZATION Semiprivate room and board, General nursing and miscellaneous hospital services and supplies.	First 60 days 61st to 90th days 91st to 150th days Beyond 150 days	All but $ [current deductible] All but $ [current amount] per day All but $ [current amount] per day $0	$0 or □ OPTIONAL PART A DEDUCTIBLE RIDER* $ [current amount] per day $ [current amount] per day 100% of Medicare eligible expenses**	
SKILLED NURSING FACILITY CARE You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital	First 20 days 21st through 100th day 101st day and after	All approved amounts All but $ [current amount] per day $[0]	$0 Up to $[ ] a day $0	
INPATIENT PSYCHIATRIC CARE Inpatient psychiatric care in a participating psychiatric hospital		190 days per lifetime	175 days per lifetime	

BLOOD	First 3 pints Additional amounts	$0 100%	First 3 pints $0	

* These are optional riders. You purchased this benefit if the box is checked and you paid the premium

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid as provided in the policy's "Core Benefits."

MEDICARE SUPPLEMENT POLICIES - PART B BENEFITS

Note: Issuers should include only the wording that applies to their policy's "This Policy Pays" column and complete the "You Pay" column.

Note: Add the following text in a bold or contrasting color if the policy is a Medicare Supplement High Deductible Plan as defined in sub. (5) (k) or (m) only until December 31, 2005: This high deductible plan pays the same as a non-high deductible plan after one has paid a calendar year [$] deductible. Benefits will not begin until out-of-pocket expenses are $[ ]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include [the plan's separate foreign travel emergency deductible].

MEDICARE PART B BENEFITS	PER CALENDAR YEAR	MEDICARE PAYS	[AFTER YOU PAY A $ [ ] DEDUCTIBLE] THIS POLICY PAYS	YOU PAY
MEDICAL EXPENSES. Eligible expense for physician's services, in-patient and out-patient medical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First $[ ] of Medicare approved amounts* Remainder of Medicare approved amounts	$ 0 Generally 80%	$0 or □ OPTIONAL PART B DEDUCTIBLE RIDER** Generally 20% □ OPTIONAL MEDICARE PART B EXCESS CHARGES RIDER**	
BLOOD	First 3 pints Next $[ ] of Medicare approved amounts* Remainder of Medicare approved	$0 $0 80%	All costs [$[ ] (Part B deductible)] 20%	

	amounts			
CLINICAL LABORATORY SERVICES Tests for diagnostic services		100%	$0	
HOME HEALTH CARE		100% of charges for visits considered medically necessary by Medicare	40 visits or □ OPTIONAL ADDITIONAL HOME HEALTH CARE RIDER**	
PREVENTIVE MEDICAL CARE BENEFIT – NOT COVERED BY MEDICARE. Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare.	First $120 each calendar year Additional charges	$0 $0	$120 [$0] or $[dollar amount]	

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

**These are optional riders. You purchased this benefit if the box is checked and you paid the premium.

OUTLINE OF COVERAGE - B

(COMPANY NAME)

OUTLINE OF MEDICARE SUPPLEMENT 50% and 25% COST-SHARING PLANS

(The designation required by sub. (5) (n) 1. and (o) 1.)

You will pay [half or one quarter] the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[ ] each calendar year. The amounts that count toward your annual limit are noted with diamonds (◊) in the chart below. Once you reach the annual limit, the policy plays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

MEDICARE COST-SHARING PART A – HOSPITAL SERVICES – PER BENEFIT PERIOD

Note: Issuers should include only the wording that applies to their policy's "This Policy Pays" column and complete the "You Pay" column.

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

SERVICES	PER BENEFIT PERIOD	MEDICARE PAYS	AFTER YOU PAY A $[ ] DEDUCTIBLE THIS POLICY PAYS	YOU PAY
HOSPITALIZATION Semiprivate room and board, General nursing and miscellaneous hospital services and supplies.	First 60 days 61st to 90th days 91st to 150th days Beyond 150 days	All but $ [current deduct-Ible] All but $ [current amount] per day All but $ [current amount] per day $0	$[ ] (50% or 75% of Part A deductible) $ [current amount] per day $ [current amount] per day 100% Medicare eligible expenses**	◊
SKILLED NURSING FACILITY CARE You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital	First 20 days 21st through 100th day 101st day and after	All approved amounts All but $ [current amount] per day $0	$0 Up to $[ ] a day $0	◊
INPATIENT PSYCHIATRIC CARE Inpatient psychiatric care in a participating psychiatric hospital		190 days per lifetime	175 days per lifetime	
BLOOD	First 3 pints Additional amounts	$0 100%	[50% or 75%] $0	◊
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.		Generally, most Medicare eligible expenses for outpatient drugs and inpatient respite care	[50% or 75%] of coinsurance or copayments	◊

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid as provided in the policy's "Core Benefits."

MEDICARE COST-SHARING POLICIES - PART B BENEFITS

Note: Issuers should include only the wording which applies to their policy's "This Policy Pays" column and complete the "You Pay" column.

MEDICARE PART B BENEFITS	PER CALENDAR YEAR	MEDICARE PAYS	AFTER YOU PAY A $[ ] DEDUCTIBLE THIS POLICY PAYS	YOU PAY
MEDICAL EXPENSES. Eligible expense for physician's services, in-patient and out-patient medical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First $[ ] of Medicare approved amounts*	$ 0	$0	◊
	Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts.	
	Remainder of Medicare approved amounts.	Generally 80%	Generally [10% or 15%]	◊
BLOOD	First 3 pints	$0	[50% or 75%]	◊
	Next $[ ] of Medicare approved amounts*	$0	$0	◊
	Remainder of Medicare approved amounts	Generally 80%	Generally [10% or 15%]	◊
CLINICAL LABORATORY SERVICES Tests for diagnostic Services		100%	$0	
HOME HEALTH CARE		100% of charges for visits considered medically necessary by Medicare	40 visits or □ OPTIONAL ADDITIONAL HOME HEALTH CARE RIDER**	

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

**These are optional riders. You purchased this benefit if the box is checked and you paid the premium.

OUTLINE OF COVERAGE - C

(COMPANY NAME)

OUTLINE OF MEDICARE COST INSURANCE

(The designation and caption required by sub. (7) (a))

MEDICARE COST PART A – HOSPITAL SERVICES – PER BENEFIT PERIOD

Note: Issuers should include only the wording that applies to their policy's "This Policy Pays" column and complete the "You Pay" column.

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

Note: Add the following bracketed information that is appropriate for a Medicare cost policy with either basic or enhanced benefits.

SERVICES	PER BENEFIT PERIOD	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
HOSPITALIZATION Semiprivate room and board, General nursing and miscella-neous hospital services and supplies.	First 60 days 61st to 90th days 91st to 150th days Beyond 150 days	All but $(current deduct-Ible] All but $ [current amount] per day All but $ [current amount] per day $0	$0 or □ OPTIONAL PART A DEDUCTIBLE RIDER* $[current amount] per day $[current amount] per day 100% of Medicare eligible expenses**	
SKILLED NURSING FACILITY CARE You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital	First 20 days 21st through 100th day 101st day and after	All approved amounts All but $[current amount] per day $0	$0 $0 $0	
INPATIENT PSYCHIATRIC CARE Inpatient psychiatric care in a participating psychiatric		190 days per lifetime	[$0 or 175 days per lifetime]	

hospital				
BLOOD	First 3 pints Additional amounts	$0 100%	First 3 pints $0	

* These are optional riders. You purchased this benefit if the box is checked and you paid the premium

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid as provided in the policy's "Core Benefits."

MEDICARE COST POLICIES - PART B BENEFITS

Note: Issuers should include only the wording that applies to their policy's "This Policy Pays" column and complete the "You Pay" column.

Note: Add the following bracketed information that is appropriate for a Medicare cost policy with either basic or enhanced benefits.

MEDICARE PART B BENEFITS	PER CALENDAR YEAR	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
MEDICAL EXPENSES. Eligible expense for physician's services, in-patient and out-patient medical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment	First [$] of Medicare approved amounts* Remainder of Medicare approved amounts	$ 0 Generally 80%	$0 or □ OPTIONAL PART B DEDUCTIBLE RIDER** Generally 20%	
BLOOD	First 3 pints Next $[ ] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 $0 80%	All [$[ ] (Part B deductible)] 20%	
CLINICAL LABORATORY SERVICES Tests for diagnostic services		100%	$0	

HOME HEALTH CARE		100% of charges for visits considered medically necessary by Medicare	40 visits □ OPTIONAL ADDITIONAL HOME HEALTH CARE RIDER**	

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

**These are optional riders. You purchased this benefit if the box is checked and you paid the premium.

OUTLINE OF COVERAGE - D

(COMPANY NAME)

OUTLINE OF MEDICARE SELECT INSURANCE AND MEDICARE SELECT 50% and 25% COST-SHARING PLANS

(The designation and caption required by sub. (30) (i) 8. and 9., or the designation required by subs. (30) (q) 1. and (r) 1.)

Note: Add the following text if the policy is a Medicare Select 50% or 25% Cost-Sharing Plan: You will pay [half or one quarter] the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[ ] each calendar year. The amounts that count toward your annual limit are noted with diamonds (◊) in the chart below. Once you reach the annual limit, the policy plays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

MEDICARE SELECT PART A – HOSPITAL SERVICES – PER BENEFIT PERIOD

Note: Issuers should include only the wording that applies to their policy's "This Policy Pays" column and complete the "You Pay" column.

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

SERVICES	PER BENEFIT PERIOD	MEDICARE PAYS	AFTER YOU PAY A $ [ ] DEDUCTIBLE THIS POLICY PAYS	YOU PAY
HOSPITALIZATION Semiprivate room and board, General nursing and miscella-neous hospital services and supplies.	First 60 days	All but $[current deduct-Ible]	$[ ] or [ ]% of Medicare Part A deductible	◊
	61st to 90th days	All but $[current amount] per day	$[current amount] per day	
	91st to 150th days	All but $[current amount] per day	$[current amount] per day	

	Beyond 150 days	$0	100% of Medicare eligible expenses **	
SKILLED NURSING FACILITY CARE You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital	First 20 days 21st through 100th day 101st day and after	All approved amounts All but $ [current amount] per day $0	$0 Up to $[ ] a day $0	◊
INPATIENT PSYCHIATRIC CARE Inpatient psychiatric care in a participating psychiatric hospital		190 days per lifetime	175 days per lifetime	
BLOOD	First 3 pints Additional amounts	$0 100%	[3 pints] or [%] $0	◊
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited coinsurance for outpatient drugs and inpatient respite care	$0 or [ ]% of coinsurance or copayments	◊

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid as provided in the policy's "Core Benefits."

MEDICARE SELECT POLICIES - PART B BENEFITS

Note: Issuers should include only the wording that applies to their policy's "This Policy Pays" column and complete the "You Pay" column.

MEDICARE PART B BENEFITS	PER CALENDAR YEAR	MEDICARE PAYS	[AFTER YOU PAY A $[ ] DEDUCTIBLE THIS POLICY PAYS	YOU PAY
MEDICAL EXPENSES In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:	First $[ ] of Medicare approved amounts [Preventive Benefits for Medicare covered services**]	$0 [Generally [ ]% or more of Medicare approved amounts**]	[$[ ] (Part B deductible)] or $0 [Remainder of Medicare approved amounts**]	◊

	Remainder of Medicare approved amounts	Generally 80%	Generally [10% or 15%]	◊
BLOOD	First 3 pints Next $ [ ] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 $0 Generally 80%	[ ]% $0 Generally [10% or 15%]	◊ ◊ ◊
CLINICAL LABORATORY SERVICES Tests for diagnostic services		100%	$0	
[HOME HEALTH CARE]		100% of charges for visits considered medically necessary by Medicare	365 necessary visits for medically necessary services	
[PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare.]*	[First $120 each calendar year] [Additional charges]**	[$0] [$0]**	[$120] [$0] or $[dollar amount]**	

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

** NOTE: Insurers should include in the outline of coverage the appropriate preventive benefit based upon whether or not the policy is a cost-sharing policy.

SECTION 33. Section Ins 3.39 Appendix 3 is repealed and recreated to read:
Ins 3.39 Appendix 3

ADVERTISING TRANSMITTAL FORM
MEDICARE SUPPLEMENT

Ref. Section 601.42 (2), Wis. Stat.
Section Ins 3.39 (15), Wis. Adm. Code
Section Ins 6.05, Wis. Adm. Code

Office of the Commissioner of Insurance
Bureau of Market Regulation
P.O. Box 7873
Madison, WI 53707-7873
(608) 266-3585

PLEASE REFER TO INSTRUCTIONS ATTACHED WHEN COMPLETING FORM. ALL LISTINGS SHOULD BE SUBMITTED IN DUPLICATE FOR EACH INSURANCE COMPANY AND INSURANCE AGENT.

1. Company OCI Number or Agent License Number	**FOR OCI USE ONLY** 2. Submission Number
3. Company Name and Mailing Address or Agent Name and Mailing Address	4. Individual Responsible for This Filing
	5. Telephone Number

6. Advertisement Title	7.* Form Number	8. Coverage Class (Numeric)	9. Coverage Code (Alpha)	10. Type of Advertisement

*Entries in this column should not be more than 30 characters including spaces.

If more space is required, use additional forms

11. ☐ Certification of Compliance Ref. s. Ins 3.39 (15), Wis. Adm. Code

FOR OFFICE USE ONLY

DATE RECEIVED

Advertisement Filing

Date Filed: _____

Initials: _____

OCI 26-042 (R 01/2005)

MEDICARE SUPPLEMENT ADVERTISING
FORM LISTING INSTRUCTIONS

State of Wisconsin
Office of the Commissioner of Insurance
Bureau of Market Regulation
P.O. Box 7873
Madison, Wisconsin 53707-7873
(608) 266-3585

Every Medicare Supplement advertisement used by a company or agent must be filed with the Commissioner's office before use. If the company's name is mentioned in the advertisement, the company will file the advertisement. If no company name is mentioned, it is the agent's responsibility to file the advertisement with the Commissioner.

Advertisement is broadly defined in s. Ins 3.27 (5), Wis. Adm. Code, and includes printed and published material, audio visual material and descriptive literature used in newspapers, magazines, other periodicals, radio and TV scripts, the Internet, Web pages, electronic or computer presentations, billboards and similar displays. It also includes descriptive literature and sales aids of all kinds issued by an insurer or agent for presentation to members of the public, and prepared sales talks.

SECTION 1 Enter the company's 9-digit Federal Tax Identification Number or the agent's 8-digit license number.

SECTION 2 FOR OCI USE ONLY. Leave blank.

SECTION 3 Enter the legal company name and address or the agent's name and address as it appears on the Wisconsin license.

SECTION 4 Enter the name of the person responsible for the filing.

SECTION 5 Enter the area code, telephone number and extension of the person responsible for the filing.

SECTION 6 Enter the Advertisement form title.

SECTION 7 Enter the form number of the Advertisement **EXACTLY** as it appears on the form, including spaces, commas, periods, slashmarks, parentheses, dashes, hyphens and any other characters. Enter the Product Category from the attached Product Category and Code list.

SECTION 8 Leave blank.

SECTION 9 Enter the Product Code listed under the product category you selected in section 8.

SECTION 10 Enter the letter "I" for Informational.

General. The form listing should be completed neatly and legibly with black ink or typescript. You may create your own form as long as it follows the format. **ALL FILINGS SHOULD BE SUBMITTED IN DUPLICATE IF YOU WISH TO RECEIVE A STAMPED COPY OF THE FILING.**

OCI 26-042A (R 01/2005)

Product Categories and Codes

Product Category (in bold)

Product Codes	Description
Group Accident & Health	
MDC	Medicare Cost
MDS	Medicare Select
MSP	Medicare Supplement
Health Maintenance Organization (HMO)	
GMC	Group Medicare Cost
GMS	Group Medicare Select
IMC	Individual Medicare Cost
IMS	Individual Medicare Select
Individual Accident & Health	
MDC	Medicare Cost
MDS	Medicare Select
MSP	Medicare Supplement
Preferred Provider Plan (PPP)	
GMC	Group Medicare Cost
GMS	Group Medicare Select
IMC	Individual Medicare Cost
IMR	Individual Medicare Risk
IMS	Individual Medicare

OCI 26-042A (R 01/2005)

SECTION 34. Section Ins 3.39 Appendix 4 is repealed and recreated to read:

Ins 3.39 Appendix 4

[NOTICE OF CHANGE FOR OUTLINE OF COVERAGE]

(COMPANY NAME)
NOTICE OF CHANGES IN MEDICARE AND YOUR [MEDICARE SUPPLEMENT OR MEDICARE REPLACEMENT] COVERAGE – 2_____

THE FOLLOWING CHART BRIEFLY DESCRIBES THE MODIFICATIONS IN MEDICARE AND IN YOUR [MEDICARE SUPPLEMENT OR MEDICARE REPLACEMENT] COVERAGE.

PLEASE READ THIS CAREFULLY!

[Note: A brief description of the revisions to Medicare Parts A and B with a parallel description of supplemental benefits with subsequent changes, including dollar amounts, provided by the Medicare supplement or Medicare replacement coverage in substantially the following format.]

SERVICES	MEDICARE BENEFITS		YOUR [MEDICARE SUPPLEMENT OR MEDICARE REPLACEMENT] COVERAGE	
	In 2____, Medicare Pays Per Benefit Period	Effective January 1, 2____, Medicare will Pay	In 2____, Your Coverage Pays	Effective January 1, 2____, Your Coverage will Pay Per Calendar Year
MEDICARE PART A SERVICES AND SUPPLIES				
HOSPITALIZATION Inpatient Hospital Services, Semi-Private Room & Board, Misc. Hospital Services & Supplies, such as Drugs, X-Rays, Lab Tests & Operating Room	All but $___ for the first 60 days/benefit period All but $___ a day for 61st-90th days/benefit period All but $___ a day for 91st-150th days (if individual chooses to use 60 nonrenewable lifetime reserve days) $0 for additional 365 days $0 beyond additional 365 days.	All but $___ for the first 60 days/benefit period All but $___ a day for 61st-90th days/benefit period All but $___ a day for 91st-150th days (if individual chooses to use 60 nonrenewable lifetime reserve days)		
SKILLED NURSING FACILITY CARE Skilled nursing care in a facility approved by Medicare. Confinement must meet Medicare standards. You must have been in a hospital for at least 3 days and enter the facility within 30 days after discharge.	First 20 days 100% of costs All but $___ (current amount per day) for the 21st - 100th day $[0] of the 101st day and thereafter.	First 20 days 100% of costs All but $___ (current amount per day) for the 21st - 100th day $[0] of the 101st day and thereafter.		
BLOOD	Pays all costs except	$0 for first 3 pints.		

	payment of deductible (equal to costs for first 3 pints) each calendar year. Part A blood deductible reduced to the extent paid under Part B	100% of additional amounts		
MEDICARE PART B SERVICES AND SUPPLIES				
MEDICAL EXPENSES Eligible expense for physician's services, medical services in and out patient, physical and speech therapy, diagnostic tests, and durable medical equipment.	After $[ ] deductible, generally 80% of remainder of Medicare approved amounts	After $[ ] deductible, generally 80% of remainder of Medicare approved amounts		
HOME HEALTH CARE	100% of charges for visits considered medically necessary by Medicare		40 visits	
PREVENTIVE MEDICAL CARE BENEFIT Some annual physical and preventive tests and services administered or ordered by your doctor when NOT covered by Medicare	$0	$0	$120	

[Note: Describe any coverage provisions changing due to Medicare modifications. Include information about when premium adjustments that may be necessary due to changes in Medicare benefits will be effective.]

THIS CHART SUMMARIZES THE CHANGES IN YOUR MEDICARE BENEFITS AND IN YOUR MEDICARE SUPPLEMENT OR MEDICARE REPLACEMENT] COVERAGE PROVIDED BY (COMPANY) ONLY BRIEFLY DESCRIBES SUCH BENEFITS. FOR INFORMATION ON YOUR MEDICARE BENEFITS CONTACT YOUR SOCIAL SECURITY OFFICE OR THE CENTERS FOR MEDICARE & MEDICAID SERVICES. FOR INFORMATION ON YOUR [MEDICARE SUPPLEMENT OR MEDICARE REPLACEMENT] POLICY CONTACT:

[COMPANY OR FOR AN INDIVIDUAL POLICY - NAME OF AGENT]
[ADDRESS/PHONE NUMBER]

SECTION 35. Section Ins 3.39 Appendix 5 is amended to read:

Ins 3.39 Appendix 5

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT, MEDICARE COST, MEDICARE SELECT, MEDICARE ADVANTAGE OR EXISTING ACCIDENT AND SICKNESS INSURANCE

(Insurance company's name and address)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to [your application] [information you have furnished], you intend to terminate existing ~~medicare~~Medicare supplement, Medicare cost, Medicare select or Medicare Advantage insurance ~~or other health insurance~~ and replace it with a policy to be issued by [Company

Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that the purchase of this Medicare supplement, Medicare cost, Medicare select or Medicare Advantage coverage is a wise decision, you should terminate your present Medicare supplement, Medicare cost, Medicare select, or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement, Medicare cost, Medicare select or Medicare Advantage policy will not duplicate your existing Medicare supplement, Medicare cost, Medicare select or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement, Medicare cost, Medicare select coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s):

_____Additional benefits.
_____No change in benefits, ~~and~~but lower premiums.
_____Fewer benefits and lower premiums.
_____ My plan has prescription drug coverage and I am enrolling in Medicare Part D.
_____ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. [optional only for Direct Mailers.]
_____
_____
_____
_____Other.(please specify)
_____
_____
_____
_____

1. Note: If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions ~~which~~that you may presently have (pre–existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate, may not contain new preexisting condition waiting periods. The insurer will waive any time periods applicable to preexisting conditions waiting periods in the new policy (or coverage) for similar benefits to the extent such time was satisfied under the Medicare supplement policy.

3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your ~~medical/health~~medical and health history. Failure to include all requested material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all requested

information has been properly reported. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure you want to keep it.

_____
(Signature of Agent, Broker or Other Representative)*
[Typed Name and Address of Issuer, Agent or Broker]

_____
(Applicant's Signature)

_____
(Date)

* Signature not required for direct response sales.

SECTION 36. Section Ins 3.39 Appendix 6 is repealed and recreated to read:

Ins 3.39 Appendix 6

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

TYPE[1] _____
For the State of _____
NAIC Group Code_____
Address _____
Title _____

SMSBP[2] _____
Company Name _____
NAIC Company Code _____
Person Completing Exhibit _____
Telephone Number _____

Line		(a) Earned Premium[3]	(b) Incurred Claims[4]
1.	Current Year's Experience		
	a. Total (all policy years)		
	b. Current year's issues[5]		
	c. Net (for reporting purposes = 1a – 1b)		
2.	Past Year's Experience (all policy years)		
3.	Total Experience (Net Current Year + Past Year)		
4.	Refunds Last Year (Excluding Interest)		
5.	Previous Since Inception (Excluding Interest)		
6.	Refunds Since Inception (Excluding Interest)		
7.	Benchmark Ratio Since Inception (se worksheet for Ratio 1)		
8.	Experience Ratio Since Inception (Ratio 2) Total Actual Incurred Claims (line 3 col. b) Total Earned Prem. (line 3, col. a) – Refunds Since Inception (line 6)		
9.	Life Years Exposed Since Inception. If the Experience Ratio is less than the Benchmark Ration, and there are more than 500 life years exposure, then proceed to calculation of refund.		
10.	Tolerance Permitted (obtained from credibility table)		

Medicare Supplement Credibility Table

Life Years Exposed	
Since Inception	Tolerance
10,000+	0.0%

5,000 – 9,999	5.0%
2,500 – 4,999	7.5%
1,000 – 2,4999	10.0%
500 – 999	15.0%
If less than 500, no credibility.	

11.	Adjusted to Incurred Claims for Credibility Ratio 3 = Ratio 2 + Tolerance	

If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required.
If Ratio 3 is less than the Benchmark Ratio, then proceed.

12.	Adjusted Incurred Claims [Total Earned Premiums (line 3, col. a) – Refund Since Inception (line 6)] x Ratio 3 (line 11)	
13.	Refund = Total Earned Premiums (line 3, col. a) – Refunds Since Inception (line 6) – [Adjusted Incurred Claims (line 12) / Benchmark Ratio (Ratio 1)]	

1 Individual, Group, Individual Medicare select, or Group Medicare select Only.
2. "SMSBP" = Standardized Medicare Supplement Benefit Plan – Use "P" for prestandardized plans.
3. Includes Modal Loadings and Fees Charged.
4. Excludes Active Life Reserves
5. This is to be used as "Issue Year Earned Premium" for Year 1 of Next Year's "Worksheet for Calculation of Benchmark Ratios."

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund or credit against premiums to be used must be attached to this form.

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name – Please Type

_____
Title – Please Type

_____
Date

REPORTING FORM FOR THE CALCULATION OF BENCHMARK
RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES
FOR CALENDAR YEAR _____

TYPE[1] _____
For the State of _____
NAIC Group Code_____
Address _____
Title _____

SMSBP[2] _____
Company Name _____
NAIC Company Code _____
Person Completing Exhibit _____
Telephone Number _____

(a)[3]	(b)[4]	(c)	(d)	(d)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Pre-mium	Factor	(b)x(c)	Cumula-tive Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumula-tive Loss Ratio	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65

4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15+[6]		4.175		0.493		8.684		0.725		0.77
Total:			(k):		(l):			(m):	(u):	

Benchmark Ratio Since Inception: (l+n)/(k+m):_____

[1] Individual, Group, Individual Medicare select, or Group Medicare select Only.
[2] "SMSBP"—Standardized Medicare Supplement Benefit Plan-Use "P" for prestandardized plans. (For Wisconsin reports show the applicable policy form number or numbers for "pooled" business.)
[3] Year I is the current calendar year-1. Year 2 is the current calendar year-2 (etc.). (Example: If the current year is 1990, then: Year 1 is 1990; Year 2 is 1989, etc.)
[4] For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
[5] These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for information purposes only.
[6] To include the earned premium for all years prior to as well as the 15th year prior to the current year.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK
RATIO SINCE INCEPTION FOR GROUP POLICIES
FOR CALENDAR YEAR

TYPE[1] _____ SMSBP[2] _____
For the State of _____ Company Name _____
NAIC Group Code_____ NAIC Company Code _____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number _____

(a)[3]	(b)[4]	(c)	(d)	(d)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Pre-mium	Factor	(b)x(c)	Cumula-tive Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumula-tive Loss Ratio	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15+[6]		4.175		0.567		8.684		0.838		0.89
Total:			(k):		(l):			(m):	(u):	

Benchmark Ratio Since Inception: (l+n)/(k+m): _____

1 Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
2 "SMSBP"=Standardized Medicare Supplement Benefit Plan-Use "P" for prestandardized plans. (For Wisconsin reports show the applicable policy form number or numbers for "pooled" business.)
3 Year I is the current calendar year-1. Year 2 is the current calendar year-2 (etc.). (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)
4 For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
5 These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for information purposes only.
6 To include the earned premium for all years prior to as well as the 15th year prior to the current year.

SECTION 37. Section Ins 3.39 Appendix 8 is amended to read:

Ins 3.39 Appendix 8

DISCLOSURE STATEMENTS

(a) [For policies that reimburse expenses incurred for specified disease(s) or other specified impairment(s). This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

●__hospital or medical expenses up to the maximum stated in the policy. ~~Medicare generally pays for most or all of these expenses.~~

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

●__hospitalization
●__physician services
●__hospice
●__[outpatient prescription drugs if you are enrolled in Medicare Part D]
●__other approved items and services

Before You Buy This Insurance

____~~●~~√__Check the coverage in **all** health insurance policies you already have.

____~~●~~√__For more information about Medicare and Medicare Supplement insurance, review the "~~Guide to Health Insurance for People with Medicare~~ *Wisconsin Guide to Health Insurance for People with Medicare*," available from the insurance company.

____~~●~~√__For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(~~aL~~b) [Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense–incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- __hospitalization
- __physician services
- __hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- __other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the "*Wisconsin Guide to Health Insurance for People with Medicare*," available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(~~b~~c) [For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- __hospitalization
- __physician services
- __hospice
- __[outpatient prescription drugs if you are enrolled in Medicare Part D]
- __other approved items and services

Before You Buy This Insurance

____•√__Check the coverage in **all** health insurance policies you already have.

____•√__For more information about Medicare and Medicare Supplement insurance, review the "~~Guide to Health Insurance for People with Medicare~~ *Wisconsin Guide to Health Insurance for People with Medicare*," available from the insurance company.

____•√__For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(~~bL~~d) [Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- __hospitalization
- __physician services
- __hospice
- __[outpatient prescription drugs if you are enrolled in Medicare Part D]
- __other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the "*Wisconsin Guide to Health Insurance for People with Medicare*," available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(~~e~~e) [For indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:
___•___any expenses or services covered by the policy are also covered by Medicare.

Medicare generally pays ~~the~~for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
•__hospitalization

•__physician services

•__hospice

• [outpatient prescription drugs if you are enrolled in Medicare Part D]

•__other approved items and services

Before You Buy This Insurance

____•√__Check the coverage in **all** health insurance policies you already have.
____•√__For more information about Medicare and Medicare Supplement insurance, review the "*Wisconsin Guide to Health Insurance for People with Medicare,*" available from the insurance company.

____•√__For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(~~e~~L~~f~~) [Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- __hospitalization
- __physician services
- __hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- __other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the "*Wisconsin Guide to Health Insurance for People with Medicare*," available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(g) [For other health insurance policies not specifically identified in the previous statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:
__●___the benefits stated in the policy and coverage for the same event is provided by Medicare.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
●__hospitalization

●__physician services

●__hospice

● [outpatient prescription drugs if you are enrolled in Medicare Part D]

●__other approved items and services

Before You Buy This Insurance

____●√__Check the coverage in **all** health insurance policies you already have.
____●√__For more information about Medicare and Medicare Supplement insurance, review the "*Wisconsin Guide to Health Insurance for People with Medicare*," available from the insurance company.

____●√__For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(~~g~~Lh) [Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
●__hospitalization

●__physician services

●__hospice

● [outpatient prescription drugs if you are enrolled in Medicare Part D]

●__other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the "*Wisconsin Guide to Health Insurance for People with Medicare*," available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

SECTION 38. Section Ins 18.02 (1) is amended to read:

Ins 18.02 (1) "Health benefit plan" has the meaning provided in s. 632.83, Stats., and includes Medicare supplement and Medicare replacement plans as defined in ss. 600.03 (28p) and (28r), Stats., and ss. Ins 3.39 (3) (~~f~~v) and (~~g~~w). Health benefit plan includes Medicare ~~Cost~~ cost and ~~Select~~select plans but does not include ~~Medicare + Choice~~ Medicare Advantage plans.

SECTION 39. Section Ins 18.10 (3) is amended to read:

Ins 18.10 (3) "Health benefit plan" has the meaning provided in s. 632.835, Stat., and includes Medicare supplement and Medicare replacement plans as defined in ss. 600.03 (28p) and (28r), Stats., and ss. Ins 3.39 (3) (~~f~~v) and (~~g~~w). Health benefit plan includes Medicare ~~Cost~~ cost and ~~Select~~select plans but does not include ~~Medicare + Choice~~ Medicare Advantage plans.

SECTION 40. INITIAL APPLICABILITY. This rule first applies to policies issued on or after January 1, 2006, except as otherwise provided in s. 3.39 (4) (a) 20.

SECTION 41. EFFECITVE DATE. This rule shall take effect on the first day of the month following publication in the Wisconsin administrative register as provided in s. 227.22 (2) (intro.), Stats.

Dated at Madison, Wisconsin, this _____ day of _____, 2005.

_____
Jorge Gomez
Commissioner of Insurance

Office of the Commissioner of Insurance
Private Sector Fiscal Analysis

for Rule Ins 339 relating to Medicare supplement, Medicare replacement, Medicare cost, Medicare select, Advantage and Medicare Part D prescription drug plans

This rule change will have no significant effect on the private sector regulated by OCI. Insurers offering Medigap policies (basic Medicare supplement, Medicare replacement, and Medicare select policies) will incur costs associated with developing new Medigap policies and marketing materials, mailing riders and explanatory materials to existing policyholders and reprogramming claim processing systems. However, these costs are offset by the insurers' ability to continue offering Medigap policies to Wisconsin consumers.

The MMA prohibits insurance companies and insurance agents from marketing in Wisconsin current Medigap policies after December 31, 2005. Failure to amend s. Ins 3.39, Wis. Adm. Code, will mean that Wisconsin Medicare beneficiaries will not have access to coverage that supplements Medicare benefits.

Wisconsin Department of Administration
Division of Executive Budget and Finance
DOA-2047 (R10/2000)

FISCAL ESTIMATE WORKSHEET

Detailed Estimate of Annual Fiscal Effect

		LRB Number	Amendment No. if Applicable
☒ ORIGINAL	☐ UPDATED		
☐ CORRECTED	☐ SUPPLEMENTAL	Bill Number	Administrative Rule Number **INS 339**

Subject
Medicare supplement, replacement, cost, select, advantage and Medicare Part D prescription drug plans

One-time Costs or Revenue Impacts for State and/or Local Government (do not include in annualized fiscal effect):
None

Annualized Costs:	**Annualized Fiscal impact on State funds from:**	
A. State Costs by Category	**Increased Costs**	**Decreased Costs**
State Operations - Salaries and Fringes	**$ 0**	**$ -0**
(FTE Position Changes)	(**0** FTE)	(**-0** FTE)
State Operations - Other Costs	**0**	**-0**
Local Assistance	**0**	**-0**
Aids to Individuals or Organizations	**0**	**-0**
TOTAL State Costs by Category	**$ 0**	**$ -0**
B. State Costs by Source of Funds	**Increased Costs**	**Decreased Costs**
GPR	**$ 0**	**$ -0**
FED	**0**	**-0**
PRO/PRS	**0**	**-0**
SEG/SEG-S	**0**	**-0**
C. State Revenues Complete this only when proposal will increase or decrease state revenues (e.g., tax increase, decrease in license fee, etc.)	**Increased Rev.**	**Decreased Rev.**
GPR Taxes	**$ 0**	**$ -0**
GPR Earned	**0**	**-0**
FED	**0**	**-0**
PRO/PRS	**0**	**-0**
SEG/SEG-S	**0**	**-0**
TOTAL State Revenues	**$ 0 None**	**$ -0 None**

NET ANNUALIZED FISCAL IMPACT

	STATE	LOCAL
NET CHANGE IN COSTS	$ **None 0**	$ **None 0**
NET CHANGE IN REVENUES	$ **None 0**	$ **None 0**

Prepared by: Julie E. Walsh	**Telephone No.** (608) 264-8101	**Agency** Insurance
Authorized Signature:	**Telephone No.**	**Date** (mm/dd/ccyy)

Wisconsin Department of Administration
Division of Executive Budget and Finance
DOA-2048 (R10/2000)

FISCAL ESTIMATE

☒ ORIGINAL ☐ UPDATED

☐ CORRECTED ☐ SUPPLEMENTAL

LRB Number	Amendment No. if Applicable
Bill Number	Administrative Rule Number **INS 339**

Subject

Medicare supplement, replacement, cost, select, advantage and Medicare Part D prescription drug plans

Fiscal Effect

State: ☒ No State Fiscal Effect

Check columns below only if bill makes a direct appropriation or affects a sum sufficient appropriation.

☐ Increase Existing Appropriation ☐ Increase Existing Revenues
☐ Decrease Existing Appropriation ☐ Decrease Existing Revenues
☐ Create New Appropriation

☐ Increase Costs - May be possible to Absorb Within Agency's Budget ☐ Yes ☐ No

☐ Decrease Costs

Local: ☒ No local government costs

1. ☐ Increase Costs ☐ Permissive ☐ Mandatory
2. ☐ Decrease Costs ☐ Permissive ☐ Mandatory
3. ☐ Increase Revenues ☐ Permissive ☐ Mandatory
4. ☐ Decrease Revenues ☐ Permissive ☐ Mandatory
5. Types of Local Governmental Units Affected: ☐ Towns ☐ Villages ☐ Cities ☐ Counties ☐ Others _____ ☐ School Districts ☐ WTCS Districts

Fund Sources Affected ☐ GPR ☐ FED ☐ PRO ☐ PRS ☐ SEG ☐ SEG-S

Affected Chapter 20 Appropriations

Assumptions Used in Arriving at Fiscal Estimate

Long-Range Fiscal Implications

None

Prepared by: Julie E. Walsh	**Telephone No.** (608) 264-8101	**Agency** Insurance
Authorized Signature:	**Telephone No.**	**Date** (mm/dd/ccyy)