5. Except for a Medicare Supplement 1 policy for which a specific requirement is set out in subsection (5) (a) 3. c., limit coverage of outpatient psychiatric treatment to 50% of the reasonable and necessary charges and to a lifetime benefit of $500.

6. Contain a pre-existing condition waiting period provision as provided in subsection (4) (a) 2.

(b) Where the insured chooses not to enroll in Medicare Part B, the insurer may exclude from coverage the expenses which Medicare Part B would cover. Medicare Part B expenses incurred beyond what Medicare Part B would cover may not be excluded.

(7) NURSING HOME, HOSPITAL CONFINEMENT INDEMNITY AND SPECIFIED DISEASE COVERAGES. (a) Captions for the policies listed in this subsection shall be:

1. Printed and conspicuously placed on the first page of the Outline of Coverage,

2. Printed on a separate form attached to the first page of the policy, and

3. Printed in 18-point bold capital letters.

(b) Nursing Home Coverage.

1. The Outline of Coverage for a policy subject to subsection (5) which provides Skilled Nursing Facility Coverage shall contain clear and conspicuous statements that:

a. The nursing home coverage will not cover all nursing home expenses,

b. Only eligible nursing home expenses as defined in the policy will be covered.

c. Medicare pays no benefits for custodial care or rest home care, and

d. The policy, unless it provides otherwise, pays no benefits for custodial or rest home care.

2. A policy form which has not been approved by the commissioner under subsection (5) and which provides coverage for confinement or care in a nursing home shall provide such coverage for confinement in any nursing facility and may not exclude coverage because a nursing facility is not Medicare-certified. Such a policy sold to Medicare eligible persons shall bear the following Caption: THE NURSING HOME BENEFIT OF THIS POLICY DOES NOT RELATE IN ANY WAY TO MEDICARE. IT WILL NOT COVER CUSTODIAL CARE OR REST HOME CARE. FOR MORE INFORMATION, CONSULT THE COMMISSIONER'S PAMPHLET "HEALTH INSURANCE ADVICE FOR SENIOR CITIZENS" WHICH YOU RECEIVED WITH THE APPLICATION FOR THIS POLICY.

3. A policy which covers nursing home custodial care or rest home care may be described in the Caption as covering such care, if such Caption is accurately and reasonably worded to indicate, for example, that the policy provides limited custodial care or rest home care.

(c) Hospital Confinement Indemnity Coverage. A policy form providing hospital confinement indemnity coverage sold to a Medicare eligible person shall bear the following Caption: THE HOSPITAL CONFINEMENT INDEMNITY BENEFIT OF THIS POLICY IS NOT DESIGNED TO FILL THE GAPS IN MEDICARE. IT WILL PAY YOU ONLY A STATED DOLLAR AMOUNT FOR A DESIGNATED NUMBER OF DAYS WHEN YOU ARE HOSPITAL CONFINED. FOR MORE INFORMATION, CONSULT THE COMMISSIONER'S PAMPHLET "HEALTH INSURANCE ADVICE FOR SENIOR CITIZENS" WHICH YOU RECEIVED WITH THE APPLICATION FOR THIS POLICY.

(d) Specified Disease Coverage. A policy form providing benefits only for one or more specified diseases sold to a Medicare eligible person shall bear:

1. The following Designation: SPECIFIED OR RARE DISEASE LIMITED POLICY, and

2. The following Caption: THIS POLICY IS DESIGNED TO COVER ONLY ONE OR MORE SPECIFIED OR RARE ILLNESSES. IT SHOULD NOT BE PURCHASED AS A SUBSTITUTE FOR HEALTH CARE EXPENSE COVERAGE WHICH WOULD GENERALLY COVER ANY ILLNESS OR INJURY. FOR MORE INFORMATION, CONSULT THE COMMISSIONER'S PAMPHLET "HEALTH INSURANCE ADVICE FOR SENIOR CITIZENS" WHICH YOU RECEIVED WITH THE APPLICATION FOR THIS POLICY.

(8) CONVERSION OR CONTINUATION OF COVERAGE. (a) An Outline of Coverage as described in par. (e) and a copy of the current edition of the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" shall be furnished by an insurer upon request to each insured who will become eligible for Medicare and is offered a conversion policy under the terms of a group insurance policy.

(b) An insurer:

1. Which provides group insurance coverage shall furnish annually to each group policyholder written notice of the availability of the information described in pars. (a) or (d), where applicable, and upon request shall furnish sufficient copies of the same or similar notice to the group policyholder to be distributed to group members affected; and

2. Which provides individual or family insurance coverage shall furnish an Outline of Coverage as described in par. (e) and a copy of the current edition of the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" at the time an insured who will become eligible for Medicare is furnished an application for conversion.

(c) Except as provided under par. (d), an insurer shall furnish an Outline of Coverage and a copy of the current edition of the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" within 14 calendar days after receipt of the request for such information.

(d) Upon request, a comprehensive written explanation of the insurance coverage to be provided after Medicare eligibility and a copy of the current edition of the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" shall be furnished by the insurer within 14 cal-

endar days after receipt of the request to each insured who will become eligible for Medicare whose coverage under an individual, family or group insurance policy will continue with changed benefits (e.g. "carve-out" or reduced benefits).

(e) The Outline of Coverage:

1. For a conversion policy which relates its benefits to or complements Medicare shall comply with subsection (4) (b) 1., 2., 3., and 6. of this rule and shall be submitted to the commissioner; and

2. For a conversion policy not subject to subd. 1. shall comply with subsection (7), where applicable, and section Ins 3.27 (5) (1).

(9) "HEALTH INSURANCE ADVICE FOR SENIOR CITIZENS" PAMPHLET. Every prospective Medicare eligible purchaser of any policy subject to this rule or coverage added to an existing Medicare Supplement policy must receive a copy of the current edition of the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" at the time the prospect is contacted by an intermediary or insurer with an invitation to apply as defined in Ins 3.27 (5) (g). This pamphlet prepared by the Office of the Commissioner of Insurance provides information on Medicare and advice to senior citizens on the purchase of Medicare supplement insurance and other health insurance. Insurers may obtain copies of this pamphlet from the commissioner at cost or may reproduce this pamphlet themselves. This pamphlet shall be periodically revised to reflect changes in Medicare and any other appropriate changes. No insurer shall be responsible for providing applicants the revised pamphlet until 30 days after the insurer has received notice that the revised pamphlet is available at the commissioner's office.

(10) APPROVAL NOT A RECOMMENDATION. While the commissioner may authorize the use of a particular Designation on a policy in accordance with this rule, that authorization is not to be construed or advertised as a recommendation of any particular policy by the commissioner or the state of Wisconsin.

(11) SEVERABILITY. If any provision of this rule or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the rule which can be given effect without the invalid provision or application, and to this end the parts of the rule are declared to be severable.

(12) EFFECTIVE DATE. This rule shall take effect January 1, 1978.

Note: Subsequent to the adoption of this rule but prior to its effective date the pamphlet required by sub. (9) shall be revised pursuant to the procedures of that subsection. The revised pamphlet shall include information on this rule and contain other appropriate changes.

Note: Insurers may use current supplies of forms which comply with subs. (7), (8) and (9) of the original rule which became effective January 1, 1978, until those supplies are exhausted, but all forms subject to newly created sub. (7) shall comply with this rule as amended by July 1, 1979.

History: Cr. Register, July, 1977, No. 259, eff. 8-1-77; am. (13), Register, September, 1977, No. 261, eff. 10-1-77; am. (2), (3) (d), (4) (a) 1., (4) (b) 1. a., 3. e. and 4., (5) (a) 3. a., (5) (b) 3. intro., 3. a., 3. b., (5) (c) 3. a. and b., (5) (d) 3. a., (5) (e) 3. intro. and a., r. and recr. (4) (b) 5., (6), (7), (8) and (9), r. (10), renum. (11) to (13) to be (10) to (12), cr. (4) (b) 6. and 7., Register, December, 1978, No. 276, eff. 1-1-79; am. (4) (b) 1.a., (5) (a) 2. and (b) 2., (5) (c) 2. and (9), r. (5) (d) and (e), Register, April, 1981, No. 304, eff. 5-1-81.

Ins 3.40 Authorized clauses for coordination of benefit provisions in group and blanket disability insurance policies [ss. 631.20, 631.21 (1) (b), 631.23, 631.43, 632.77 (3)]. (1) PURPOSE. This section establishes authorized coordination of benefit clauses for group and blanket disability insurance policies pursuant to s. 631.23, Stats., because it has been found that provision of language, content or form of these specific clauses is necessary to provide certainty of meaning of them, and regulation of contract forms will be more effective and litigation will be substantially reduced is there is increased uniformity of these clauses. This section does not require the use of coordination of benefit or "other insurance" provisions but if such provisions are used, they must adhere substantially to this section. Liberalization of the prescribed language including rearrangement of the order of the clauses is permitted provided that the modified language is not less favorable to the insured person. Provisions for the reduction in benefits because of other insurance which are inconsistent with this section violate the criteria of s. 631.20, Stats., and may not be used.

(2) SCOPE. This section applies to all group and blanket disability insurance policies subject to s. 631.01 (1), Stats., providing 24-hour coverage for medical or dental care, treatment or expenses due to either injury or sickness which contain a coordination of benefits provision, an "excess," "anti-duplication," "non-profit" or "other insurance" clause or other provision, clause or exclusion by whatever name designated under which benefits would be reduced because of other insurance, other than an exclusion for expenses covered by workers compensation, employer's liability insurance or Medicare. A plan of coverage, such as major medical or excess medical, designed to be supplementary to a group or blanket policyholder's other coverage may provide that the plan shall be excess to that specific policyholder's plan of basic coverage from whatever source provided.

(3) AUTHORIZED CLAUSES. The clauses in subs. (4) to (10) shall be considered authorized clauses pursuant to s. 631.23, Stats., for use in policy forms subject to this section and collectively are a coordination of benefits provision and may be referred to as "this provision."

(4) BENEFITS SUBJECT TO THIS PROVISION. All of the benefits provided under this policy are subject to this provision.

(5) BENEFITS SUBJECT TO THIS PROVISION [Alternate Clause]. Only the major medical expense benefits provided under this policy are subject to this provision. [When the policy provides both integrated major medical expense benefits and the basic benefits, but the "other insurance" provision applies to the major medical expense benefits only, this alternate wording is authorized.]

(6) DEFINITIONS. (a) "Plan" means any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by group, blanket or franchise insurance coverage, service insurance plan contracts, group practice, individual practice and other prepayment coverage, or any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employe benefit organization plans, and any coverage under governmental programs, and any coverage required or provided by statute.

Ins 3.42 Plans of conversion coverage. Pursuant to s. 632.897 (4) (b), Stats., the following plans of conversion coverage are established.

(1) *Plan 1—Basic Coverage*—Plan 1 basic coverage consists of the following:

(a) Hospital room and board daily expense benefits in a maximum dollar amount approximating the average semi-private rate charged in the major metropolitan area of this state, for a maximum duration of 70 days per calendar year;

(b) Miscellaneous in-hospital expenses, including anesthesia services, up to a maximum amount of 20 times the hospital room and board daily expense benefits per calendar year; and

(c) In-hospital and out-of-hospital surgical expenses payable on a usual, customary and reasonable basis up to a maximum benefit of $2,000 a calendar year.

(2) *Plan 2—Major Medical Expense Coverage*—Plan 2 major medical expense coverage shall consist of benefits for hospital, surgical and medical expenses incurred either in or out of a hospital of the following:

(a) A lifetime maximum benefit of $75,000.

(b) Payment of benefits at the rate of 80% of covered medical expenses which are in excess of the deductible, until 20% of such expenses in a benefit period reaches $1,000, after which benefits will be paid at 100% for the remainder of the benefit period; provided, however, benefits for out-patient mental illness, if covered by the policy, may be provide at a lesser rate, but not below 50%, and sugical expenses will be provided at a usual, customary and reasonable level.

(c) A deductible for each benefit period of $500 except that the deductible shall be $1,000 for each benefit period for a policy insuring members of a family. All covered expenses of any insured family member may be applied to satisfy the deductible.

(d) A "benefit period" shall be defined as a calendar year.

(e) Payment for all services covered under the contract by any licensed health care professional qualified to provide the services.

(3) *Plan 3—Major Medical Expense Coverage*—Plan 3 major medical expense coverage shall consist of benefits for hospital, surgical and medical expenses incurred either in or out of a hospital of the following:

(Same as Plan 2 except that maximum benefit is $100,000 and deductible is $1,000 for an individual and $2,000 for a family.)

History: Cr. Register, April, 1981, No. 304, eff. 5-1-81.

Ins 3.43 High limit comprehensive plan of benefits. (1) A policy form providing a high limit comprehensive plan of benefits may be approved as an individual conversion policy as provided by s. 632.897 (4) (b), Stats., if it provides comprehensive coverage of expenses of hospital, surgical and medical services of not less than the following:

(a) A lifetime maximum benefit of $250,000.

(b) Payment of benefits at the rate of 80% of covered medical expenses which are in excess of the deductible, until 20% of such expenses in a benefit period reaches $1,000, after which benefits will be paid at 100% for the remainder of the benefit period; provided, however, benefits for out-patient mental illness, if covered by the policy, may be provided at a lesser rate, but not below 50%, and surgical expenses will be provided at a usual, customary and reasonable level.

(c) A deductible for each benefit period of at least $250 and not more than $500 except that the deductible shall be at least $250 and not more than $1,000 for each benefit period for a policy insuring members of a family. All covered expenses of any insured family member may be applied to satisfy the deductible.

(d) A "benefit period" shall be defined as a calendar year.

(e) Payment for all services covered under the contract by any licensed health care professional qualified to provide the services.

(2) the filing procedures of s. Ins 3.12, Wis. Adm. Code, shall apply to policy forms filed as individual conversion policies.

History: Cr. Register, April, 1981, No. 304, eff. 5-1-81.

Ins 3.44 Effective date of s. 632.897, Stats. (1) Section 632.897, Stats., applies to group policies issued or renewed on or after May 14, 1980, or if a policy is not renewed within two years after the effective date of the act, s. 632.897, Stats., is effective at the end of 2 years from May 14, 1980.

(2) (a) A group policy as defined in s. 632.897 (1) (c) 1 or 3 shall be considered to have been renewed on any date specified in the policy as a renewal date or on any date on which the insurer or the insured changed the rate of premium for the group policy.

(b) A group policy as defined in s. 632.897 (1) (c) 2. shall be considered to have been renewed on any date on which an underlying collective bargaining agreement or other underlying contract is renewed, or on which a significant change is made in benefits.

(3) Section 632.897, Stats., applies to individual policies issued or renewed after May 14, 1980, except that it shall not apply to any individual policy in force on May 13, 1980, in which the insurer does not have the option of changing premiums.

History: Cr. Register, April, 1981, No. 304, eff. 5-1-81.

Ins 3.45 Conversion policies by insurers offering group policies only. Section 632.897 (4) (d) (first sentence), Stats., establishes that an insurer offering group policies only is not required to offer individual coverage. Since the insurer has no individual conversion policies which it may offer, it may not require a terminated insured who elected to continue coverage under s. 632.897 (2), Stats., to convert to individual coverage under s. 632.897 (6), Stats., after 12 months. The terminated person may continue group coverage except as provided in s. 632.897 (3) (a), Stats.

History: Cr. Register, April, 1981, No. 304, eff. 5-1-81.