Chapter Ins 3

CASUALTY INSURANCE

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Ins 3.01 Accumulation benefit riders attached to health and accident policies. Except where such rider is used only on a policy replacing the company's own policy, and so recites, no rider providing for accumulations of benefits will be approved for use upon any policy of health and accident insurance, whether it is proposed to issue such rider with or without an additional premium. Such rider operates as an aid to twisting the policies of another company in such manner as to make its use a direct encouragement of this practice.

Ins 3.02 Automobile fleets, vehicles not included in. Individually owned motor vehicles cannot be included or covered by fleet rates. The determining factor for inclusion under fleet coverage must be ownership and not management or use.

Ins 3.04 Dividends not deducted from premiums in computing loss reserves. Premiums returned to policyholders as dividends may not be

deducted from the earned premiums in computing loss reserves under s. 623.04, Stats.

History: 1-2-56; emerg. am. eff. 6-22-76; am. Register, September, 1976, No. 249, eff. 10-1-76.

Ins 3.08 Municipal bond insurance. (1) PURPOSE. This section implements and interprets ss. 601.42, 611.19 (1), 618.21, 623.03, 623.04, 627.05, 628.34 (2), 632.14, and 632.17, Stats., for the purpose of establishing minimum requirements for the transaction of a type of surety insurance known as municipal bond insurance.

(2) SCOPE. This section shall apply to the underwriting, marketing, rating, accounting and reserving activities of insurers which write municipal bond insurance.

(3) DEFINITIONS. (a) "Annual statement" means the fire and casualty annual statement form specified in s. Ins. 7.01 (5) (a).

(b) "Contingency reserve" means a reserve established for the protection of policyholders covered by policies insuring municipal bonds against the effect of excessive losses occurring during adverse economic cycles.

(c) "Cumulative net liability" means one-third of one percent of the insured unpaid principal and insured unpaid interest covered by in-force policies of municipal bond insurance.

(d) "Municipal bonds" means securities which are issued by or on behalf of or are paid or guaranteed by:

1. Any state, territory or possession of the United States of America;

2. Any political subdivision of any such state, territory or possession; or

3. Any agency, authority or corporate or other instrumentality of any one or more of the foregoing, or which are guaranteed by any of the foregoing.

(e) "Municipal bond insurance" means a type of surety insurance authorized by s. Ins 6.75 (2) (g) which is limited to the guaranteeing of the performance and obligations of municipal bonds.

(f) "Municipal bond insurer" means an insurer which issues municipal bond insurance.

(g) "Total net liability" means the average annual amount due, net of reinsurance, for principal and interest on the insured amount of any one issue of municipal bonds.

(h) "Person" means any individual, corporation for profit or not for profit, association, partnership or any other legal entity.

(i) "Policyholders' surplus" means an insurer's net worth, the difference between its assets and liabilities, as reported in its annual statement.

(4) MINIMUM CAPITAL OR PERMANENT SURPLUS. The minimum capital or permanent surplus of a municipal bond insurer shall be $2 million for an insurer first authorized to do business in Wisconsin on or before Janu-

Service	Benefit	Basic Medicare Coverage	This Policy Pays	You Pay
HOSPITALIZATION . . . semiprivate room and board, general nursing and miscellaneous hospital services and supplies	First 60 days	All but (current deductible amount)		
	61st to 90th day	a day		
Includes meals, special care units, drugs, lab tests, diagnostic x-rays, medical supplies,	91st to 150th day	All but (current amount) a day		
operating and recovery room, anesthesia and rehabilitation services	Beyond 150 days	Nothing		
POSTHOSPITAL SKILLED NURSING CARE. . .	First 20 days	100% of costs		
In a facility approved by Medicare, you must have been in a hospital for at least three days and enter	Additional 80 days	All but (current amount) a day		
the facility within 30 days after hospital discharge.	Beyond 100 days	Nothing		
MEDICAL EXPENSE	Physician's services, inpatient and outpatient medical services and supplies at a hospital, physical and speech therapy and ambulance.	80% of reasonable charge [after current deductible]		

(5) (Statement that the policy does or does not cover the following:)

(a) Private duty nursing,

(b) Skilled nursing home care costs (beyond what is covered by Medicare),

(c) Custodial nursing home care costs,

(d) Intermediate nursing home care costs,

(e) Home health care above number of visits covered by Medicare,

(f) Physician charges (above Medicare's reasonable charge),

(g) Drugs (other than prescription drugs furnished during a hospital or skilled nursing facility stay),

(h) Care received outside of U.S.A.,

(i) Dental care of dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for the cost of eyeglasses or hearing aids.

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

(6) (A description of any policy provisions which exclude, eliminate, resist, reduce, limit, delay, or in any other manner operate to qualify payments of the benefits described in (4) above, including conspicuous statements:)

(a) (That the chart summarizing Medicare benefits only briefly describes such benefits.)

(b) (That the Health Care Financing Administration or its Medicare publications should be consulted for further details and limitations.)

(c) (That there are limitations on the choice of providers or the geographical area served, if this is the case.)

(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 in the area or out 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) (The amount of premium for this policy.)

Drafting Note: The term "certificate" should be substituted for the word "policy" throughout the outline of coverage where appropriate. The outline is subject to s. Ins 3.27 (5) (1) and (9) (u), (v) and (zh) 2. and 4.

Ins 3.40 Coordination of benefits provisions in group and blanket disability insurance policies. (1) PURPOSE. (a) This section establishes authorized coordination of benefits provisions for group and blanket disability insurance policies pursuant to s. 631.23, Stats. It has been found that these clauses are necessary to provide certainty of meaning. Regulation of contract forms will be more effective, and litigation will be substantially reduced if there is uniformity regarding coordination of benefits provisions in health insurance policies.

(b) A Coordination of benefits (COB) provision as defined in sub. (3) (e) avoids claim payment delays by establishing an order in which Plans pay their claims and by providing the authority for the orderly transfer of information needed to pay claims promptly. It avoids duplication of

benefits by permitting a reduction of the benefits of a Plan when, by the rules established by this section, a Plan does not have to pay its benefits first.

(c) Coordinating health benefits has been found to be an effective tool in containing health care costs. However, minimum standards of protection and uniformity are needed to protect the insured's and the public's interest.

(2) SCOPE. This section applies to the medical benefits provisions of all automobile insurance policies and to all group and blanket disability insurance policies subject to s. 631.01 (1), Stats., that provide coverage for medical or dental care, treatment or expenses due to either injury or sickness that contain a coordination of benefits provision, an "excess," "antiduplication," "non-profit" or "other insurance" exclusion by whatever name designated under which benefits are reduced because of other insurance, other than an exclusion for expenses covered by workers compensation, employer's liability insurance or Medicare.

(3) DEFINITIONS. In this section:

(a) "Allowable expense" means the necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made, except as provided in sub. (4).

(b) "Claim" means a request that benefits of a Plan be provided or paid. The benefits claimed may be in the form of services (including supplies), payment for all or a portion of the expenses incurred, a combination of the previous 2, or indemnification.

(c) "Claim determination period" means the period of time, not less than 12 consecutive months, over which allowable expenses are compared with total benefits payable in the absence of COB to determine whether overinsurance exists and how much each Plan will pay or provide. However, it does not include any part of a year before the date this COB provision or a similar provision takes effect.

(d) "Complying Plan" means a Plan with order of benefit determination rules which comply with this section.

(e) A "Coordination of benefits (COB) provision" means an insurance contract provision intended to avoid claims payment delays and duplication of benefits when a person is covered by 2 or more plans providing benefits or services for medical, dental or other care or treatment.

(f) "Group-type contracts" mean contracts which are not available to the general public and may be obtained and maintained only because of membership in or connection with a particular organization or group. Group-type contracts answering this description may be included in the definition of Plan at the option of the insurer issuing group-type plans or the service provider and its contract-client, whether or not uninsured arrangements or individual contract forms are used and regardless of how the group-type coverage is designated (for example, "franchise" or "blanket"). The use of payroll deductions by the employe, subscriber or member to pay for the coverage is not sufficient, of itself, to make an individual contract part of a group-type plan. Group-type contracts do not include individually underwritten and issued, guaranteed renewable

policies that may be purchased through payroll deduction at a premium savings to the insured.

(g) "Hospital indemnity benefits" mean benefits for hospital confinement which are not related to expenses incurred but does not include plans that reimburse a person for actual hospital expenses incurred even if the plans are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

(h) "Noncomplying Plan" means a Plan that declares its benefits to be "excess" or "always secondary" or that uses order of benefit determination rules inconsistent with those contained in this section.

(i) "Plan" means a form of coverage providing benefits for medical or dental care, except as limited under sub. (6), with which coordination is allowed.

(j) "Primary Plan" means a health care plan, determined by the order of benefit determination rules, whose benefits shall be determined before those of the other Plan and without taking the existence of any other Plan into consideration.

(k) "Secondary Plan" maans a plan which is not a Primary Plan according to the order of benefit determination rules and whose benefits are determined after those of another Plan and may be reduced because of the other plan's benefits.

(l) "This Plan" means the part of the group contract that provides the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans. Any other part of the group contract providing health care benefits is separate from This Plan.

(4) ALLOWABLE EXPENSE USES AND LIMITATIONS. (a) Items of expense under dental care, vision care, prescription drug or hearing aid programs may be excluded from the definition of allowable expense. A Plan which provides benefits only for these items may limit its definition of allowable expense to these items of expense.

(b) When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be considered as both an allowable expense and a benefit paid.

(c) The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense under the above definition unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice or as specifically defined in the Plan.

(d) When COB is restricted in its use to a specific coverage in a contract, for example, major medical or dental, the definition of allowable expense shall include the corresponding expenses or services to which COB applies.

(5) CLAIM DETERMINATION PERIOD USES AND LIMITATIONS. (a) A claim determination period may not be less than 12 months and usually is a calendar year, but a Plan may use some other period of time that fits the coverage of the group contract. A person may be covered by a Plan during a portion of a claim determination period if that person's coverage starts or ends during that claim determination period.

(b) As each claim is submitted, each Plan shall determine its liability and pay or provide benefits based upon allowable expenses incurred to that point in the claim determination period. However, that determination is subject to adjustment as later allowable expenses are incurred in the same claim determination period.

(6) PLAN USES, LIMITATIONS AND VARIATIONS. (a) The definition of Plan in the group contract shall state the types of coverage which shall be considered in applying the COB provision of that contract. The right to include a type of coverage is limited by the rest of this subsection.

(b) The definition of Plan shown in the model COB provision in APPENDIX A is an example of what may be used. Any definition that satisfies sub. (3) (i) and this sub. may be used.

(c) This section uses the term "Plan". However, a group contract may instead use "Program" or some other term.

(d) "Plan" shall not include individual or family insurance or subscriber contracts or individual or family coverage through health maintenance organizations (HMOs), limited service health organizations (LSHOs), or any other prepayment, group practice or individual practice plan except as provided in pars. (e) and (f).

(e) "Plan" may include: group insurance and group subscriber contracts; uninsured arrangements of group or group-type coverage; group or group-type coverage through HMOs, LSHOs and other prepayment, group practice and individual practice plans; and group-type contracts.

(f) "Plan" may include the medical benefits coverage in group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts.

(g) If "Plan" includes Medicare or other governmental benefits, that part of the definition of "Plan" may be limited to the hospital, medical and surgical benefits of the governmental program. However, "Plan" shall not include a state plan under Medicaid (Title XIX, Grants to State for Medical Assistance Programs, of the United States Social Security Act as amended from time to time) and shall not include a law or plan whose benefits, by law, are excess to those of any private insurance plan or other non-government plan.

(h) "Plan" shall not include group or group-type hospital indemnity benefits of $100 per day or less but may include the amount by which group or group-type hospital indemnity benefits exceed $100 per day.

(i)"Plan" shall not include school accident-type coverages that cover grammar, high school, and college students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis.

(j) Each contract or other arrangement for coverage is a separate Plan. If an arrangement has 2 parts and COB rules apply only to one of the 2, each of the parts is a separate Plan.

(7) PRIMARY PLAN AND SECONDARY PLAN USES AND LIMITATIONS. (a) The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person.

(b) There may be more than one Primary Plan. For example, 2 Plans which have no order of benefit determination rules would both be primary. A Plan is a Primary Plan if either subd. 1 or 2 is true:

1. The Plan either has no order of benefit determination rules, or it has rules which differ from those permitted by this regulation.

2. All plans which cover the person use the order of benefit determination rules required by this section, and under these rules the Plan determines its benefits first.

(c) When there are more than 2 plans covering the person, This Plan may be a Primary Plan as to one or more other Plans and may be a Secondary Plan as to a different Plan or Plans.

(d) If a person is covered by more than one Secondary Plan, the order of benefit determination rules of this section decide the order in which the benefits are determined in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under the rules of this section, has its benefits determined before those of that Secondary Plan.

(8) APPLICABILITY. (a) This coordination of benefits (COB) provision applies to This Plan when an employe or the employe's covered dependent has health care coverage under more than one Plan.

(b) If this COB provision applies, the order of benefit determination rules shall be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan.

(c) The benefits of This Plan shall not be reduced when, under the order of benefit determination rules, This Plan is primary and determines its benefits before another Plan.

(d) The benefits of This Plan may be reduced when, under the order of benefit determination rules, another Plan determines its benefits first.

(9) FLEXIBILITY AND CONSISTENCY WITH THIS SECTION. (a) APPENDIX A shall be considered authorized clauses pursuant to s. 631.23, Stats., for use in policy forms subject to this section and shall only be changed as provided in this section.

(b) This section permits but does not require the use of COB or "other insurance" provisions. However, if such provisions are used, they must conform with this section and substantially conform to the clauses contained in APPENDIX A. Liberalization of the prescribed language in APPENDIX A, including rearrangement of the order of the clauses, is permitted provided that the modified language is not less favorable to the insured person.

(c) Policy language which reduces benefits because of other insurance and which is inconsistent with this section violates the criteria of s. 631.20, Stats., and shall not be used.

(d) A Plan that includes a COB provision inconsistent with this section shall not take the benefits of another Plan into account when it determines its benefits. There is one exception: a contract holder's coverage that is designed to supplement a part of a basic package of benefits may

provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder.

(e) A group contract's COB provision does not have to use the words and format contained in APPENDIX A. Changes may be made to fit the language and style of the rest of the group contract or to reflect the differences among Plans which provide services, which pay benefits for expenses incurred, and which indemnify. Substantive changes are allowed only as set forth in this section.

(f) A term such as "usual and customary," "usual and prevailing," or "reasonable and customary" may be substituted for the term "necessary, reasonable and customary". Terms such as "medical care" or "dental care" may be substituted for "health care" to describe the coverages to which the COB provisions apply.

(g) A group contract may apply one COB provision to certain of its benefits (such as dental benefits), coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

(10) PROHIBITED COORDINATION AND BENEFIT DESIGN. (a) A group contract shall not reduce benefits on the basis that:

1. Another Plan exists;

2. Except with respect to Part B of Medicare, that a person is or could have been covered under another Plan; or

3. A person has elected an option under another Plan providing a lower level of benefits than another option which could have been elected.

(b) No contract shall contain a provision that its benefits are "excess or "always secondary" to any Plan defined in sub. (3) (i), except as permitted under this section.

(11) ORDER OF BENEFIT DETERMINATION RULES. (a) 1. The Primary Plan shall pay or provide its benefits as if the Secondary Plan or Plans did not exist.

2. A Secondary Plan may take the benefits of another Plan into account only when, under the rules in par. (b), it is secondary to that other Plan.

(b) When there is a basis for a claim under This Plan and another Plan, This Plan determines its order of benefits using the first of the following rules which applies:

1. If the other Plan does not have rules coordinating its benefits with those of This Plan, the benefits of the other Plan are determined first.

2. Non-dependent or dependent. The benefits of the Plan which covers the person as an employe, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent.

3. Dependent child-parents not separated or divorced. Except as stated in subpar. c., when This Plan and another Plan cover the same child as a dependent of different persons, called "parents":

a. The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but

b. If both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

c. However, if the other Plan does not have the rule described in subpar. a., but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of beneifts, the rule in the other Plan shall determine the order of benefits.

d. In this subdivision, the word "birthday" refers only to month and day in a calendar year, not the year in which the person was born.

4. Dependent child-separated or divorced parents. If 2 or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

a. First, the Plan of the parent with custody of the child;

b. Then, the plan of the spouse of the parent with custody of the child; and

c. Finally, the Plan of the parent not having custody of the child.

d. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of the Plan of the responsible parent are determined first. This subparagraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

5. Active or inactive employe. The benefits of a Plan which covers a person as an employe who is neither laid off or retired, or as that employe's dependent, are determined before those of a Plan which covers that person as a laid off or retired employe, or as that employe's dependent. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

6. Longer or shorter length of coverage. a. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employe, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

b. To determine the length of time a person has been covered under a Plan, 2 Plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended. Thus, the start of a new Plan does not include:

1) A change in the amount or scope of a Plan's benefits;

2) A change in the entity which pays, provides or administers the Plan's benefits; or

3) A change from one type of Plan to another, such as, from a single employer plan to that of a multiple employer plan.

c. The claimant's length of time covered under a Plan is measured from the claimant's first date of coverage under that Plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present Plan has been in force.

(12) PAYMENT AS A SECONDARY PLAN. (a) In accordance with sub. (11) order of benefit determination rules, when this Plan is a Secondary Plan as to one or more other Plans, the benefits of This Plan may be reduced according to the alternatives described in par. (b), (c) or (d). Such other Plan or Plans are referred to as "the other Plans" in par. (b), (c) and (d).

(b) *Alternative 1. total allowable expenses* "Reduction in This Plan's benefits.

1. The benefits of This Plan shall be reduced when the sum of:

a. The benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision and

b. The benefits that would be payable for the allowable expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those allowable expenses in a claim determination period.

2. If that occurs, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those allowable expenses. When the benefits of This Plan are reduced as described, each benefit is reduced in proportion and is then charged against any applicable benefit limit of This Plan."

(c.) *Alternative 2. total allowable expenses with coinsurance.* "Reduction in This Plan's Benefits. The benefits of This Plan shall be reduced when the sum of:

1. The benefits that would be payable for the allowable expenses under This Plan in the absence of this COB provision; and

2. The benefits that would be payable for the allowable expenses under the other Plans in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds the greater of (i) 80% of those Allowable Expenses or (ii) the amount of the benefits in 1. above. In that case, the benefits of This Plan shall be reduced so that they and the benefits in 2. above do not total more than the greater of (i) and (ii). When the benefits of this Plan are reduced as described, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan."

(d) *Alternative 3. maintenance of benefits* "Reduction in This Plan's Benefits. 1. The benefits that would be payable under This Plan in the absence of this COB provision shall be reduced by the benefits payable under the other Plans for the expenses covered in whole or in part under This Plan. This applies whether or not a claim is made under a Plan.

2. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be considered both an expense incurred and a benefit payable.

3. When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan."

(13) CONDITIONS FOR USE OF ALTERNATIVES 1, 2 OR 3. (a) When Alternative 1 is used, a Secondary Plan may reduce its benefits so that the total benefits paid or provided by all Plans during a claim determination period are not more than total allowable expenses. The amount by which the Secondary Plan's benefits are reduced shall be used by the Secondary Plan to pay allowable expenses, not otherwise paid, which were incurred during the claim determination period by the person for whom the claim is made. As each claim is submitted, the Secondary Plan determines its obligation to pay for allowable expenses based on all claims which were submitted up to that point in time during the claim determination period.

(b) When Alternative 2 is used, a Secondary Plan may reduce its benefits so that the total benefits paid or provided by all Plans during a claim determination period are not more than a stated precentage, but not less than 80%, of total Allowable Expenses. The amount by which the Secondary Plan's benefits are reduced shall be used by the Secondary Plan to pay the stated percentage of allowable expenses not otherwise paid which were incurred during the claim determination period by the person for whom the claim is made. As each claim is submitted, the Secondary Plan determines its obligation to pay for the stated percentage of allowable expenses based on all claims which were submitted up to that point in time during the claim determination period.

(c) When alternative 3 is used, a Secondary Plan may reduce its benefits by the amount of the benefits payable under the other Plans for the same expenses.

(d) Alternative 3 may be used in a Plan only when, in the absence of COB, the benefits of the Plan, excluding benefits for dental care, vision care, prescription drug or hearing aid programs, shall, after any deductible, be:

1. Not less than 50% of covered expenses for the treatment of mental or nervous disorders, alcoholism or drug abuse in excess of mandated coverage required by s. 632.89, Stats., or for cost containment provisions with alternative benefits, such as those applicable to second surgical opinions, precertification of hospital stays, etc.; and

2. Not less than 75% of other covered expenses.

(e) A Plan using alternative 3 may exclude definitions of and references to allowable expenses, claim determination period, or both.

(f) A Plan using alternatives 2 and 3 permit a Secondary Plan to reduce its benefits so that total benefits may be less than 100% of allowable expenses. A Plan using alternative 2 or 3 shall comply with the following conditions:

1. Notice. The Plan must provide prior notice to employes or members that, when it is Secondary, its benefits plus those of the Primary Plan will be less than 100% of allowable expense unless the Primary Plan, by itself, provides benefits at 100% of allowable expenses.

2. Copayment and deductible limit. When the Plan is Secondary, it must provide a limit on the amount the employe, member or subscriber is required to pay toward the expenses or services covered under the Plan and for which the Plan is Secondary. Such limit shall not exceed $2,000 for any covered person or $3,000 for any family in any claim determination period.

3. Unrestricted enrollment. Under certain circumstances, the Plan shall permit a person to be enrolled for its health care coverage when that person's eligibility for health care coverage under another Plan ends for any reason. This will occur if the person is eligible for coverage under The Plan and the enrollment is made before the end of the 31-day period immediately following either the date when health care coverage under the other plan ends or the end of any continuation period elected by or for that person. This unrestricted enrollment is not required if a person remains eligible for coverage under that other Plan or a Plan which replaces it, without interruption of that person's coverage.

4. Enrollment requirements. If the person is enrolled before the end of the period described in subd. 3., there shall be no interruption of coverage. Thus, the requirements concerning active work of employes, members or subscribers or nonconfinement of dependents on the effective date of coverage shall not be applied. However, coverage for the person under the Plan may be subject to the same requirements including underwriting requirements, benefit restrictions, waiting periods, and pre-existing condition limitations that would have applied had the person been enrolled under the Plan on the later of either the date the person first became eligible for the Plan's coverage or the date the employe, member or subscriber last became covered under the Plan. Credit shall be given under any pre-existing condition limitation or waiting period from the later of the dates described in the preceding sentence to the date the person actually enrolled.

(14) RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION. Certain facts are needed to apply the COB rules. An insurer has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The insurer need not tell or get the consent of any person to do this. Each person claiming benefits under This Plan shall give the insurer any facts it needs to pay the claim.

(15) FACILITY OF PAYMENT. A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, the insurer responsible for payment may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The insurer will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

(16) RIGHT OF RECOVERY. If the amount of the payments made by the insurer responsible for payment, including the reasonable cash value of any benefits provided in the form of services, is more than it should have paid under a COB provision, it may recover the excess from one or more of:

(a) The persons it has paid or for whom it has paid;

(b) Insurance companies; or

(c) Other organizations.

(17) REASONABLE CASH VALUE OF SERVICES. A Secondary Plan which provides benefits in the form of services may recover the reasonable cash value of providing the services from the Primary Plan, to the extent that benefits for the services are covered by the Primary Plan and have not already been paid or provided by the Primary Plan. Nothing in this provision shall be interpreted to require a Plan to reimburse a covered person in cash for the value of services provided by a Plan which provides benefits in the form of services.

(18) EXCESS AND OTHER NONCONFORMING PROVISIONS. (a) Some Plans have order of benefit determination rules not consistent with this section which declare that the Plan's coverage is "excess" to all others or "always secondary." This may occur because:

1. Certain Plans may not be subject to insurance regulation; or

2. Some group contracts are not required to conform with this section until after the effective date of this section.

(b) A Complying Plan may coordinate its benefits with a Noncomplying Plan on the following basis:

1. If the Complying Plan is the Primary Plan, it shall pay or provide its benefits on a primary basis.

2. If the Complying Plan is the Secondary Plan, it shall pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the Complying Plan were the Secondary Plan. In such a situation, the payment shall be the limit of the Complying Plan's liability.

3. If the Noncomplying Plan does not provide the information needed by the Complying Plan to determine its benefits within a reasonable time after it is requested to do so, the Complying Plan shall assume that the benefits of the Noncomplying Plan are identical to its own and shall pay its benefits accordingly. However, the Complying Plan shall adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the Noncomplying Plan.

4. The Complying Plan shall advance to or on behalf of the employe, subscriber, or member an amount equal to the difference if the Noncomplying Plan reduces its benefits so that the employe, subscriber, or member receives less in benefits than he or she would have received had the Complying Plan paid or provided its benefits as the Secondary Plan and the Noncomplying Plan paid or provided its benefits as the Primary Plan.

5. In no event shall the Complying Plan advance more than the Complying Plan would have paid had it been the Primary Plan less any amount it previously paid. In consideration of such advance, the Complying Plan shall be subrogated to all rights of the employe, subscriber, or member against the Noncomplying Plan. Such advance by the Complying Plan shall also be without prejudice to any claim it may have against the Noncomplying Plan in the absence of such subrogation.

(19) SUBROGATION. The COB concept differs from that of subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

(20) EFFECT ON EXISTING POLICIES. This section applies to every group contract which provides health care benefits and is issued on or after January 1, 1987. A group contract which provides health care benefits and was issued before January 1, 1987 shall be brought into compliance with this rule by the later of:

(a) The next anniversary date or renewal date of the group contract;

or

(b) The expiration of any applicable collectively bargained contract pursuant to which it was written.

Note: In sub. (18) if the Noncomplying Plan is unwilling to provide the Complying Plan with the necessary information, the Complying Plan should assume the primary position in order to avoid undue claim delays and hardship to the insured. The Complying Plan may, through its subrogation rights, seek reimbursement for such payments. Undue delay in paying the claim may subject the Complying Plan to a violation of s. Ins 6.11.

History: Cr. Register, July, 1980, No. 295, eff. 9-1-80; am. (2), Register, January, 1981, No. 301, eff. 2-1-81; r. and recr. (7) (d) and (e), r. (19) under s. 13.93 (2m) (b) 16, Stats., renum. (8) to (18) to be (9) to (19), am. (20), Register, July, 1985, No. 355, eff. 8-1-85; r. and recr. Register, December, 1986, No. 372, eff. 1-1-87.

APPENDIX A

Model COB Provision

This appendix provides model COB provision language. The terms and conditions of all insurance contracts containing a COB provision must comply with Ins 3.40.

COORDINATION OF THE GROUP CONTRACT'S BENEFITS WITH OTHER BENEFITS

(I) APPLICABILITY.

(A) This Coordination of Benefits ("COB") provision applies to This Plan when an employee or the employee's covered dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

(B) If this COB provision applies, the order of benefit determination rules shall be looked at first. The rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

(i) shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but

(ii) may be reduced when, under the order of benefit determination rules, another Plan determines its benefits first. This reduction is described in Section (IV) Effect on the Benefits of This Plan.

(II) DEFINITIONS.

(A) *"Allowable Expense"* means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice or as specifically defined in the Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be considered both an Allowable Expense and a benefit paid.

(B) *"Claim Determination Period"* means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan or any part of a year before the date this COB provision or a similar provision takes effect.

(C) *"Plan"* means any of the following which provides benefits or services for, or because of, medical or dental care or treatment:

(i) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(ii) Coverage under a governmental plan or coverage that is required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program.

Each contract or other arrangement for coverage under (i) or (ii) is a separate Plan. If an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

(D) *"Primary Plan"/"Secondary Plan"*. The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans and may be a Secondary Plan as to a different Plan or Plans.

(E) *"This Plan"* means the part of the group contract that provides benefits for health care expenses.

(III) ORDER OF BENEFIT DETERMINATION RULES.

(A) *General.* When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

(i) the other Plan has rules coordinating its benefits with those of This Plan; and

(ii) both those rules and This Plan's rules described in subparagraph (B) require that This Plan's benefits be determined before those of the other Plan.

(B) *Rules.* This plan determines its order of benefits using the first of the following rules which applies:

(i) *Non-dependent/Dependent.* The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent.

(ii) *Dependent Child/Parents Not Separated or Divorced.* Except as stated in subparagraph (B) (iii), when This Plan and another Plan cover the same child as a dependent of different persons, called "parents":

a. the benefits of the Plan of the parent whose birthday falls earlier in the calendar year are determined before those of the Plan of the parent whose birthday falls later in that calendar year; but

b. if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in a. but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan shall determine the order of benefits.

(iii) *Dependent Child/Separated or Divorced Parents.* If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

a. first, the Plan of the parent with custody of the child;

b. then, the Plan of the spouse of the parent with the custody of the child; and

c. finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(iv) *Active/Inactive Employee.* The benefits of a Plan which covers a person as an employee who is neither laid off nor retired or as that employee's dependent are determined before those of a Plan which covers that person as a laid off or retired employee or as that employee's dependent. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule (iv) is ignored.

(v) *Longer/Shorter Length of Coverage.* If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

(IV) EFFECT ON THE BENEFITS OF THIS PLAN.

(A) *When This Section Applies.* This Section (IV) applies when, in accordance with Section (III) Order of Benefit Determination Rules, This Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" in (B).

ALTERNATIVE 1.

(B) *Reduction in this Plan's Benefits.* The benefits of This Plan will be reduced when the sum of:

(i) the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and

(ii) the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Note: The last paragraph may be omitted if the Plan provides only one benefit or may be altered to suit the coverage provided.

ALTERNATIVE 2.

(B) *Reduction in This Plan's Benefits.* The benefits of This Plan will be reduced when the sum of:

(i) the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and

(ii) the benefits that would be payable for the Allowable Expenses under the other Plans in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made,

exceeds the greater of (a) 80% of those Allowable Expenses or (b) the amount of the benefits in (i) above. In that case, the benefits of This Plan will be reduced so that they and the benefits in (ii) above do not total more than the greater of that (a) and (b).

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan."

ALTERNATIVE 3

(B) *Reduction in This Plan's Benefits.* The benefits that would be payable under This Plan in the absence of this COB provision will be reduced by the benefits payable under the other Plans for the expenses covered in whole or in part under This Plan. This applies whether or not claim is made under a Plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an expense incurred and a benefit payable.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan."

(V) RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

Certain facts are needed to apply these COB rules. The [name of insurance company] has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The [name of insurance company] need not tell or get the consent of any person to do this. Each person claiming benefits under This Plan must give the [name of insurance company] any facts it needs to pay the claim.

(VI) FACILITY OF PAYMENT.

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, The [name of insurance company] may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The [name of insurance company] will not have to

pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

(VII) RIGHT OF RECOVERY.

If the amount of the payments made by the [name of insurance company] is more than it should have paid under this COB provision, it may recover the excess from one or more of:

(A) the persons it has paid or for whom it has paid;

(B) insurance companies; or

(C) other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Ins 3.41 Individual conversion policies. (1) REASONABLY SIMILAR COVERAGE. An insurer provides reasonably similar coverage under s. 632.897 (4), Stats., to a terminated insured as defined in s. 632.897 (1) (f), Stats., if a person is offered individual coverage substantially identical to the terminated coverage under the group policy or individual policy, or is offered his or her choice of the 3 plans described in s. Ins 3.42, or is offered a high limit comprehensive plan of benefits approved for the purpose of conversion by the commissioner as meeting the standards described in s. Ins 3.43. Individual conversion policies must include benefits required for individual disability insurance policies by subch. VI, ch. 632, Stats.

(2) RENEWABILITY. (a) Except as provided in par. (b), individual conversion policies shall be renewable at the option of the insured unless the insured fails to make timely payment of a required premium amount, there is over-insurance as provided by s. 632.897 (4) (d), Stats., or there was fraud or material misrepresentation in applying for any benefit under the policy.

(b) Conversion policies issued to a former spouse under s. 632.897 (9) (b), Stats., must include renewal provisions at least as favorable to the insured as did the previous coverage.

(3) PREMIUM RATES. (a) In determining the rates for the class of risks to be covered under individual conversion policies, the premium and loss experience of policies issued to meet the requirements of s. 632.897 (4), Stats., may be considered in determining the table of premium rates applicable to the age and class of risks of each person to be covered under the policy and to the type and amount of coverage provided.

(b) Except as provided in par. (c), conditions pertaining to health shall not be an acceptable basis for classification of risks.

(c) A conversion policy issued to a former spouse under s. 632.897 (9) (b), Stats., may be rated on the basis of a health condition if a similar rating had been previously applied to the prior individual coverage due to the same condition.

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

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 hospital, medical, and surgical expenses which are in excess of the deductible, until 20% of such expenses in a benefit period reaches $1,000, after which benefits shall be paid at 100% for the remainder of the benefit period; provided, however, benefits for outpatient treatment of mental illness, if covered by the policy, may be limited as provided in par. (g), and surgical expenses shall be covered 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; except payment for psychologists' services may be conditioned upon referral or supervision by a physician.

(f) Payment of benefits for maternity, subject to the limitations in pars. (a),(b), and (c), if maternity was covered under the prior policy.

(g) Benefits for outpatient treatment of mental illness, if provided by the policy, may be limited to either of the following coverages at the option of the insurer:

1. At least 50% of usual, customary and reasonable expenses which are in excess of the policy deductible, subject to the policy lifetime maximum.

2. The minimum benefits for group policies described in s. 632.89 (2) (d), Stats.

(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; am. (2) (b) and (e), cr. (2) (f) and (g), Register, October, 1982, No. 322, eff. 11-1-82.

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 hospital, medical, and surgical expenses which are in excess of the deductible, until 20% of such expenses in a benefit period reaches $1,000, after which benefits shall be paid at 100% for the remainder of the benefit period; provided, however, benefits for outpatient treatment of mental illness, if covered by the policy, may be limited as provided in par. (g), and surgical expenses shall be covered 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; except payment for psychologists' services may be conditioned upon referral or supervision by a physician.

(f) Payment of benefits for maternity, subject to the limitations in pars. (a),(b), and (c), if maternity was covered under the prior policy.

(g) Benefits for outpatient treatment of mental illness, if provided by the policy, may be limited to either of the following coverages at the option of the insurer:

1. At least 50% of usual, customary and reasonable expenses which are in excess of the policy deductible, subject to the policy lifetime maximum.

2. The minimum benefits for group policies described in s. 632.89 (2) (d), Stats.

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

History: Cr. Register, April, 1981, No. 304, eff. 5-1-81; am. (1) (b) and (e), cr. (1) (f) and (g), Register, October, 1982, No. 322, eff. 11-1-82.

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 2 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.

Ins 3.46 Standards for nursing home insurance. (1) FINDINGS. Information on file in the office of the commissioner of insurance indicates that those consumers who wish to buy health insurance to cover nursing home and other long term care frequently are not able to choose the policy which is most suitable for their needs because they do not understand the coverage being offered and do not know how long term care insurance fits in with other group and individual health insurance available in the marketplace. The commissioner finds that the adoption of minimum standards and disclosure requirements for nursing home insurance policies will reduce marketing abuses in the sale of nursing home insurance, will help consumers understand what is covered in the policies being offered, and will assist them in comparing the various policies they are offered. The commissioner finds that a nursing home insurance policy which does not meet the minimum standards and disclosures of this section is misleading and deceptive under s. 628.34 (12), Stats., and the advertising and marketing of such a policy constitutes an unfair trade practice under s. 628.34 (11), Stats.

(2) PURPOSE. This section establishes minimum standards and disclosure requirements for insurance which may be sold as nursing home insurance. A policy shall be disapproved pursuant to s. 631.20 (2) (d), Stats., if the policy does not meet the minimum requirements specified in this section.

(3) SCOPE. (a) Except as provided in pars. (b) and (c), this section applies to any individual or group insurance policy or rider which provides coverage primarily for confinement or care in a licensed skilled or intermediate care facility.

(b) This section does not apply to a rider designed specifically to meet the requirements for coverage of skilled nursing care set forth in s. 632.895 (3), Stats.

(c) This section does not apply to a group policy issued to one or more employers or labor organizations or to the trustees of a fund established by one or more employers, or labor organizations, or a combination of both, for employes or former employes or both, or for members or former members or both of the labor organizations.

(d) This section also applies to any individual insurance policy issued to a person eligible for Medicare which provides coverage for confinement or care in a licensed skilled or intermediate care facility in addition to providing hospital confinement indemnity coverage as defined in s. Ins 3.27 (4) (b) 6.

(4) DEFINITIONS. For the purpose of this section:

(a) *"Custodial care"* means care which can be performed by persons without professional medical training and which is primarily for the purpose of meeting the personal needs of the patient, including feeding and personal hygiene.

(b) *"Intermediate nursing care"* means basic care including physical, emotional, social and other restorative services under periodic medical supervision. This nursing care requires the skill of the registered nurse in administration, including observation and recording of reactions and symptoms, and supervision of nursing care.

(c) *"Intermediate care facility"* means a facility licensed as an intermediate care facility by the state in which it is located.

(d) *"Irreversible dementia"* means deterioration or loss of intellectual faculties, reasoning power, memory and will due to organic brain disease characterized by confusion, disorientation, apathy and stupor of varying degrees which is not capable of being reversed and from which recovery is impossible.

(e) *"Medicare"* means the hospital and medical insurance program established by title XVIII, 42 USC 1395 to 1395ss, as amended.

(f) *"Medicare eligible persons"* means all persons who qualify for Medicare.

(g) *"Outline of coverage"* means a document which gives a brief description of benefits in the format prescribed in Appendix 1 to this section and which complies with s. Ins 3.27 (5) (1) and (9) (zh).

(h) *"Skilled nursing care"* means care furnished on a physician's orders which requires the skills of professional personnel such as a registered or a licensed practical nurse and is provided either directly by or under the supervision of these personnel.

(i) *"Skilled care facility"* means a facility licensed as a skilled nursing facility by the state in which it is located.

(5) NURSING HOME INSURANCE POLICY REQUIREMENTS. No insurance policy covered by this section shall be structured, advertised, or marketed as a nursing home insurance policy unless:

(a) The policy provides at a minimum the coverage set out in sub. (6).

(b) The policy for an individual policy and the certificate for a group policy are plainly printed in black or blue ink in a uniform type of a style

in general use, not less than 10 point with a lower case unspaced alphabet length not less than 120 point.

(c) If the policy is sold to Medicare-eligible persons, it meets the requirements of s. Ins 3.39 (7) (a) and (b).

(d)The policy and certificates define skilled and intermediate nursing care no more restrictively than the definitions in this section.

(6) MINIMUM COVERAGES. (a) Except as provided in pars. (b) through (g) of this section, a nursing home policy shall provide coverage for each person insured under the policy for skilled nursing services or intermediate nursing services received while a resident of any licensed skilled care facility or intermediate care facility.

(b) Nursing home policies may limit benefits to a fixed daily benefit. The daily benefit may differ for different levels of care, but the lowest level of daily benefits shall not be less than 50% of the highest level of benefits.

(c) Nursing home policies may provide benefits subject to an elimination period. The elimination shall be expressed in a number of days per lifetime or per period of confinement. However, if an insurer offers a policy with an elimination period of 100 days or more, it must also offer a policy with an elimination period of less than 100 days.

(d) Nursing home policies may provide benefits subject to a lifetime maximum, but the lifetime maximum shall be at least 365 days of coverage.

(e) Nursing home policies shall offer coverage for both skilled and intermediate nursing care.

(f) Nursing home policies are not required to duplicate payments by Medicare for nursing home care.

(g) Nursing home policies may limit coverage to care certified as medically necessary according to generally accepted standards of medical practice and recertified periodically. Insurers shall consider but are not necessarily bound by an attending physician's determination of the level of care the patient is receiving.

(h) Nursing home policies may limit benefits to care received after a hospitalization under the following conditions:

1. Any insurer offering a policy which requires prior hospitalization must also offer an identical policy which does not require a prior hospitalization.

2. The prior hospitalization requirement shall be no more than three days and shall not be applied to any person with irreversible dementia who requires either skilled or intermediate nursing care in a skilled or intermediate care facility and is otherwise eligible for benefits under the policy.

3. The caption described in sub. (8) (d) includes a statement which accurately describes the prior hospitalization requirement.

(i) The following limitations and exclusions are prohibited in nursing home policies.

1. Coverage limiting or excluding benefits for any form of irreversible dementia.

2. Coverage which conditions eligibility for intermediate care benefits on the prior receipt of skilled care benefits.

(7) RENEWABILITY. An insurer may not alter or terminate any policy subject to this section on an individual basis except for nonpayment of premium. The insurer may alter or terminate a policy if it alters or terminates all similar policies on a class basis.

(8) DISCLOSURE REQUIREMENTS. (a) Insurers and intermediaries shall provide to all prospective purchasers of any policy subject to this section an outline of coverage at the time the prospect is first contacted by an intermediary or insurer with an invitation to apply as defined in s. Ins 3.27 (5) (g).

(b) The outline of coverage shall be printed in an easy to read type in language which is easy to understand.

(c) The outline of coverage shall be approved by the commissioner prior to use.

(d) The policy for an individual policy, the certificate for a group policy and the outline of coverage for both shall contain the following caption printed in 12 point type in a style in general use:

The Wisconsin insurance commissioner's office has established minimum standards for nursing home insurance. This policy meets those standards.

This policy covers only certain types of nursing home care. It will not pay for all care in all nursing homes. PLEASE READ YOUR POLICY AND OUTLINE OF COVERAGE CAREFULLY TO BE SURE THAT YOU UNDERSTAND THE BENEFITS.

(e) If the policy is offered to a Medicare eligible person, the outline of coverage shall comply with s. Ins 3.39 (7) (a) and (b).

(9) LOSS RATIO REQUIREMENTS. (a) The anticipated loss ratio shall be at least 55% in the case of individual policies, at least 55% in the case of group policies issued as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising, and at least 75% in the case of other group policies.

(b) The loss ratio shall be approved along with the policy form.

(c) The loss ratio shall be computed on the basis of anticipated incurred claims and earned premiums as estimated for the entire period for which rates are computed to provide coverage, in accordance with accepted actuarial principles and guidelines.

Note: Section Ins. 3.46, revised effective January 1, 1987, first applies to policies issued after March 1, 1987.

History: Cr. Register, June, 1981, No. 305, eff. 11-1-81; cr. (3) (c), Register, June, 1982, No. 318, eff. 7-1-82; am. (1) and (3) (b), Register, March, 1985, No. 351, eff. 4-1-85; (6m) deleted under s. 13.93 (2m) (b) 16, Stats., Register, March, 1985, No. 351; r. and recr. Register, December, 1986, No. 372, eff. 1-1-87.

APPENDIX 1

(COMPANY NAME)

OUTLINE OF COVERAGE

NURSING HOME INSURANCE POLICY

(The caption required by s. Ins 3.46 (8) (d))

(The caption required by s. Ins 3.39 (7) (a) and (b) if policy is offered to a person eligible for Medicare)

(1) The outline shall contain the following language: Read Your Policy Carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company.

(2) The outline shall contain the following language: This is a Nursing Home Insurance Policy. Policies of this category are designed to pay some of the costs of nursing home care. A policy in this category pays for skilled and intermediate care in a state licensed facility. *This policy will not pay for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing and taking medicine.* (This may be modified to reflect actual benefits in policy).

(3) The outline shall contain a brief description of the benefits in the policy in the format outlined below. Variations in this format to accommodate a particular policy may be permitted.

SCHEDULE OF BENEFITS

Type Of Care	Daily Benefit	Deductible	Maximum ($s and Days)
Skilled Care			
Intermediate Care			
Custodial Care			

(4) The outline shall contain a description of the following items, if applicable:

(a) Pre-existing condition limitations

(b) Waiting periods

(c) Exclusions and limitations in the policy

(d) Prior authorization procedures

(e) Benefit periods in the policy

(f) Renewability provisions of the policy

(g) Conditions for terminating coverage

(h) "Free look" provisions in the policy

(i) Prior hospitalization requirements

(5) The outline shall contain the definitions of skilled nursing care, intermediate nursing and, if applicable, custodial care included in this section.

(6) The outline shall contain a statement that the policy will cover skilled or intermediate care for persons with irreversible dementia if the person is receiving either of these levels of care and is otherwise eligible for benefits.

(7) A complete schedule of current premiums for all classifications and a statement concerning circumstances under which premiums are subject to change.

Ins 3.47 Cancer insurance solicitation. (1) FINDINGS. Information on file in the office of the commissioner of insurance shows that significant misunderstanding exists with respect to cancer insurance. Consumers are not aware of the limitations of cancer insurance and do not know how cancer insurance policies fit in with other health insurance coverage. Many of the sales presentations used in the selling of cancer insurance are confusing, misleading and incomplete and consumers are not getting the information they need to make informed choices. The commissioner of insurance finds that such presentations and sales materials are misleading, deceptive and restrain competition unreasonably as considered by s. 628.34 (12), Stats., and that their continued use without additional information would constitute an unfair trade practice under s. 628.34 (11) and would result in misrepresentation as defined and prohibited in s. 628.34 (1), Stats.

(2) PURPOSE. The purpose of s. Ins 3.47 is to promulgate a rule interpreting s. 628.34 (12), relating to unfair trade practices. It requires insurers and intermediaries who sell cancer insurance to give all prospective buyers of cancer insurance a buyer's guide prepared by the national association of insurance commissioners.

(3) SCOPE. This section applies to all individual, group and franchise insurance polices or riders which provide benefits for or are advertised as providing benefits primarily for the treatment of cancer. This rule does not apply to solicitations in which the booklet, "Health Insurance Advice for Senior Citizens," is given to applicants as required by s. Ins 3.39.

(4) DEFINITION. The "Information Sheet on Cancer Insurance" means the document which contains, and is limited to, the language set forth in Appendix I to this section.

(5) DISCLOSURE REQUIREMENTS. (a) The insurer and its intermediaries shall print and provide to all prospective purchasers of any policy subject to the rule a copy of the "Information Sheet on Cancer Insurance" at the time the prospect is contacted by an intermediary or insurer with an invitation to apply as defined in s. Ins 3.27 (5) (g).

(b) The "Information Sheet on Cancer Insurance" shall be printed in an easy to read type and not less than 12 pt. size.

(6) This rule shall become effective August 1, 1981.

History: Cr. Register, June, 1981, No. 306, eff. 8-1-81.