Chapter Ins 3

CASUALTY INSURANCE

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) a day		
	61st to 90th day			
Includes meals, special care units, drugs, lab tests, diagnostic x-rays, medical supplies, operating and recovery room, anesthesia and rehabilitation services	91st to 150th day	All but (current amount) a day		
	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 the facility within 30 days after hospital discharge.	Additional 80 days	All but (current amount) a day		
	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 nonparticipating 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 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 if 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.

(am) The term "Plan" shall be construed separately with respect to each policy, contract or other arrangement for benefit or services and separately with respect to that portion of any policy, contract or other arrangement which reserves the right to take benefits or services of other plans into consideration in determining its benefits and that portion which does not.

(b) "This Plan" means that portion of this policy which provides the benefits that are subject to this provision. Any benefits provided under this policy that are not subject to this provision constitute another Plan.

(c) "Allowable Expense" means any necesary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the Plans covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

(d) "Claim Determination Period" means _____. [Insert here an appropriate period of time such as "Calendar year" or "Benefit Period as defined elsewhere in this policy."]

(7) EFFECT ON BENEFITS. (a) This provision shall apply in determining the benefits as to a person covered under this Plan for any Claim Determination Period if, for the Allowable Expense incurred as to such person during such period, the sum of

1. The benefits that would be payable under this Plan in the absence of this provision, and

2. The benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to this provision would exceed such allowable Expenses.

(b) As to any Claim Determination Period with respect to which this provision is applicable, the benefits that would be payable under this Plan in the absence of this provision for the Allowable Expenses incurred as to such person during such Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other Plans, except as provided in par. (c), shall not exceed the total of the Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made therefor.

(c) 1. If another Plan which is involved in par. (b) and which contains a provision coordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined, and

2. The other Plan's provision coordinating its benefits with those of this Plan includes Claim Determination Period and Facility of Payment provisions similar to those of this provision, and

3. The rules set forth in this subsection would require this Plan to determine its benefits before any other Plan then the benefits of the other Plan will be ignored for the purposes of determining the benefits under this Plan.

(8) ORDER OF BENEFIT DETERMINATION. For the purposes of sub. (7) (c), the rules establishing the order of benefit determination are:

(a) The benefits of a Plan which covers the person on whose expenses claim is based other than as a dependent shall be determined before the benefits of a Plan which covers the person as a dependent;

(b) For claims incurred prior to July 1, 1986, and except as provided under par. (c) 2., the benefits of a Plan which covers the person on whose expenses claim is based as a dependent of a male person shall be determined before the benefits of a Plan which covers the person as a dependent of a female person; except that in case of a person for whom a claim is made as a dependent child.

1. When parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody of the child shall be determined before the benefits of a Plan which covers the child as a dependent of the parent without custody;

2. When parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a dependent of the stepparent, and the benefits of a Plan which covers that child as a dependent of the stepparent shall be determined before the benefits of a Plan which covers that child as a dependent of the parent without custody;

3. Notwithstanding subds. 1. and 2., if there is a court decree which otherwise establishes financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a dependent child.

(c) For claims incurred on or after July 1, 1986,

1. Except as provided in subd. 2., the benefits of a Plan which covers the person on whose expenses claim is based as a dependent of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year shall be determined before the benefits of a Plan which covers such person as a dependent of a person whose date of birth, excluding year of birth, occurs later in a calendar year. If either Plan does not have the provisions of this subdivision regarding dependents, which results either in each Plan determining its benefits before the other or in each Plan determining its benefits after the other, the provisions of this subdivision do not apply, and the rule set forth in the Plan which does not have the provisions of this subdivision shall determine the order of benefits.

2. If a claim is made for a dependent child whose parents are separated or divorced, the order of benefit determination as set forth in (b) 1. to 3. shall apply.

(d) When pars. (a), (b), and (c) do not establish an order of benefit determination, the benefits of a Plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered the person the shorter period of time, provided that:

1. The benefits of a Plan covering the person on whose expenses claim is based as a laid-off or retired employe, or dependent of such person, shall be determined after the benefits of any other Plan covering the person as an employe, other than a laid-off or retired employe, or dependent of such person; and

2. If either Plan does not have a provision regarding laid-off or retired employes, which results in each Plan determining its benefits after the other, then the provisions of subd. 1. shall not apply.

(e) When this subsection operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during any Claim Determination Period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and the reduced amount shall be charged against any applicable benefit limit of this Plan. This clause may be omitted if the Plan provides only one benefit.

(9) RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION. For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provision of similar purpose of any other Plan, the insurer or service plan may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which the insurer or service plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the insurer or service plan such information as may be necessary to implement this provision.

(10) FACILITY OF PAYMENT. Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plans, the insurer or service plan shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it determines to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of the payments, the insurer or service plan shall be fully discharged from liability under this Plan.

(11) RIGHT OF RECOVERY. Whenever payments have been made by the insurer with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the insurer or service plan shall have the right to recover such payments, to the extent of any excess, from among one or more of the following, as the insurer or service plan shall determine: any persons to or for or with respect to whom such payments were made, any other insurers, service plans or any other organizations.

(12) LIMITATIONS ON AND VARIATIONS FROM DEFINITION OF PLAN. The definition of a Plan in sub. (6) (a) enumerates the types of coverage which the insurer may consider in determining whether overinsurance exists with respect to a specific claim. The authorized definition clause may be varied in accordance with the substance of the following:

(a) The definition may not include individual or family policies, or individual or family subscriber contracts, except as authorized in pars. (b) through (f).

(b) The definition may include all group policies or group subscriber contracts as well as such group-type contracts as are not available to the general public and can be obtained and maintained only because of the covered person's membership in or connection with a particular organization or group. Group-type contracts answering this description may be

included in the definition, at the option of the insurer and its policyholder-client, whether or not individual policy forms are utilized and whether the group-type coverage is designated as "franchise" or "blanket" or in some other fashion.

(c) The definition may include both group and individual automobile "no-fault" contracts but, as to the traditional automobile "fault" contracts, only the medical benefits written on a group or group-type basis may be included.

(d) The definition may not include group or group-type hospital indemnity benefits written on a nonexpense incurred basis of $30 per day or less unless they are characterized as reimbursement type benefits but are designed or administered so as to give the insured the right to elect indemnity type benefits, in lieu of such reimbursement type benefits, at the time of claim. In any event, the amount of group and group-type hospital indemnity benefits which exceeds $30 per day may be construed as being included under the definition of a "Plan."

(e) The definition may not include school accident type coverages, written on either an individual, group, blanket or franchise basis. In this context, school accident type coverages are defined to mean coverage covering grammar school and high school students for accidents only, including athletic injuries, either on a 24-hour basis or "to and from school," for which the parent pays the entire premium.

(f) If Medicare or similar governmental benefits are included in the definition of a Plan, such benefits may be taken into consideration without expanding the definition of Allowable Expenses beyond the hospital, medical and surgical benefits as may be provided by the government program.

(13) DETERMINATION OF LENGTH OF TIME COVERED. (a) In determining the length of time an individual has been covered under a given Plan, two successive Plans of a given group shall be deemed to be one continuous Plan so long as the claimant concerned was eligible for coverage within 24 hours after the prior Plan terminated. Thus, neither a change in the amount or scope of benefits provided by a Plan, a change in the carrier insuring the Plan, nor a change from one type of Plan to another, [e.g., single employer to multiple employer Plan, or vice versa, or single employer to a Taft-Hartley Welfare Plan] would constitute the start of a new Plan for purposes of this section.

(b) If a claimant's effective date of coverage under a given Plan is subsequent to the date the carrier first contracted to provide the Plan for the group concerned (employer, union, association, etc.), then, in the absence of specific information to the contrary, the carrier shall assume, for purposes of this section, that the claimant's length of time covered under that Plan shall be measured from the claimant's effective date of coverage. If a claimant's effective date of coverage under a given Plan is the same as the date the carrier first contracted to provide the Plan for the group concerned, then the carrier shall request the group concerned to furnish the date the claimant first became covered under the earliest of any prior Plans the group may have had. If such 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 coverage under that Plan has been in force.

(14) COORDINATION OF BENEFITS WITH OTHER PLAN WHOSE COVERAGE IS EXCESS TO ALL OTHER COVERAGE. It is recognized that there may be existing group plans containing provisions under which the coverage is declared to be "excess" to all other coverages, or other overinsurance provisions not consistent with the provisions of this section. Such plans may have been written by self-insured or nonregulated entities not presently subject to insurance regulation, or by insurers or service corporations under policies or contracts issued prior to the effective date of this section which have not yet been brought into conformance with this section. Carriers are urged to use the following claims administration procedures when one plan is "excess" to all other coverages and their policy or contract contains the coordination of benefits provisions of this section. A plan containing a coordination of benefits provision should pay first if it would be primary according to the oder of benefit determination of sub. (7). In those cases where a group coordination of benefits plan would normally be considered secondary, the insurer should make every effort to coordinate in a secondary position with benefits available through any such "excess" plan. The insurer should try to secure the necessary information from the "excess" plan. But if such excess plan is unwilling to provide the carrier with the necessary information, the carrier should assume the primary position in order to avoid undue claim delays and hardship to the insured.

(15) COORDINATION OF BENEFITS PAYABLE. Insurers are urged to use the following claims administration procedures to expedite claim payments where coordination of benefits is involved:

(a) Improving exchange of benefit information;

(b) There should be continued and improved education of claim personnel, stressing accurate and prompt completion of the HIC Duplicate Coverage Inquiry (DUP-1) Form by the inquiring insurer and the responding insurer. This education effort should also be encouraged through local claim associations;

(c) Claim personnel should be encouraged to make every effort, including use of the telephone, to speed up exchange of coordination of benefits information;

(d) Insurers should encourage building a local data file of other group plans in the area, with at least basic information on group health plans for major employers;

(e) Each insurer should establish a time limit after which full or partial payment should be made. When payment of a claim is necessarily delayed for reasons other than the application of a coordination of benefits provision, investigation of other valid coverage should be conducted concurrently so as to create no further delay in the ultimate payment of benefits. Occasionally this will necessitate an insurer making payment as the primary insurer with a right of recovery in the event that subsequent investigation proves that payment as a secondary insurer should have been made.

(16) SMALL CLAIMS WAIVER. Insurers are urged to waive the investigation of possible other coverage for coordination of benefits purposes on claims less than $50, but if additional liability is incurred to raise the small claim above $50, the entire liability may be included in the coordination of benefits computation.

(17) SUBROGATION. The concept of coordination of benefits is clearly distinguishable from that of subrogation. Provisions for either may be included in a group disability insurance policy without compelling the inclusion or exclusion of the other.

(18) EDUCATION OF INSUREDS. Each insurer has an affirmative obligation to urge its respective group clients to take reasonable steps to assure that those insured by the group policy or subscriber contract have been exposed to reasonably concise explanations, with as little technical terminology as is commensurate with accuracy, as to the purpose and operation of coordination of benefits. Such educational effort may take the form of articles in the employer magazines or newspapers, speeches before the appropriate labor organization in the case of a unionized employer, brochures added to pay envelopes, notices on the company bulletin board, materials used by personnel department in counseling employes, and the like.

(19) DISCLOSURE OF COORDINATION OF BENEFIT CLAUSES IN CERTIFICATES OF COVERAGE. Each certificate of coverage under a group disability policy or contract which provides coordination of benefits pursuant to this section shall contain, at least in summary form, a description of the coordination of benefit clauses.

(20) EFFECTIVE DATE. Group and blanket disability policies issued or renewed on or after August 1, 1985 shall contain the order of benefit determination as described in sub. (8).

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.

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 bar-

gaining 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 shows that significant misunderstanding exists with respect to nursing home insurance. In many cases, coverage under these policies is much less than the use of the label would warrant and includes few meaningful benefits beyond those already available to consumers as a result of s. 632.895 (3), Stats., and Ins 3.39, and the commissioner of insurance finds that such policies are inequitable, misleading, deceptive, obscure, and encouraging of misrepresentation as considered by s. 631.20 (2), Stats. Some of the sales presentations used to sell nursing home insurance are misleading, confusing, and incomplete, and the commissioner of insurance finds that such presentations are misleading and deceptive, and restrain competition unreasonably under s. 628.34 (12), Stats., and their continued use would constitute an unfair trade practice under s. 628.34 (11), Stats.

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

(b) This section seeks to reduce abuses and confusion associated with the sale of nursing home insurance by providing for minimum levels of coverage. It is designed not only to improve the ability of the consumer to make an informed choice as to whether to purchase a nursing home policy, but to assure that no policy will be approved by the commissioner as a "nursing home policy" unless it contains coverage which warrants the use of that label.

(3) SCOPE. (a) Except as provided in par. (b), this section applies to any individual insurance policy or rider which provides coverage primarily for confinement or care in a nursing home. This section applies regardless of restrictions on the level of nursing home care provided by a policy, i.e., skilled, intermediate, limited, personal or residential care.

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

(c) This section applies to any individual insurance policy issued on or after July 1, 1982 to a person eligible for Medicare by reason of age which provides coverage for confinement or care in a nursing home 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) "Medicare" means the hospital and medical insurance program established by title XVIII of the federal social security act of 1965, as amended.

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

(c) "Nursing home" means a nursing home as defined by s. 50.01 (3), Stats.

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

(a) The policy provides at a minimum the coverage set out in sub. (6) of this section and applicable statutes.

(b) The policy is plainly printed as to text in black or blue ink in a type of a style in general use, the size of which is uniform and 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) (b).

(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 any care received while a resident of any nursing home licensed by the state of Wisconsin pursuant to s. 50.02, Stats.

(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 $10 a day.

(c) Nursing home policies may provide benefits subject to a deductible, but the deductible amount shall not exceed 60 days per lifetime.

(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 may limit coverage to care certified as necessary by the attending physician and periodically recertified as necessary.

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

(g) The following limitations and exclusions are prohibited in nursing home policies:

1. Coverge limited to only certain levels of care, such as skilled care.

2. Coverage limited to care received as a result of sickness or injury.

3. Coverage limited to care received after a hospital confinement.

(7) EFFECTIVE DATE. This rule shall take effect November 1, 1981.

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.

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.