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Chapter Ins 3

CASUALTY INSURANCE

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Note: Corrections made under s. 13.93 (2m) (b) 7., Stats., Register, August, 1997, No. 500.

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 7.02, Forms 22−010 and 22−011.

(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 January 1, 1984, or the amount required by statute

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or administrative order after that date for other municipal bond insurers.

(5) LIMITATIONS AND RESTRICTIONS. (a) Policies of municipal bond insurance shall be issued only to provide coverage on bonds of the type defined in sub. (3) (d).

(b) A municipal bond insurer may not have total net liability in respect to any one issue of municipal bonds in excess of an amount representing 10% of its policyholders' surplus.

(c) A municipal bond insurer may not have outstanding cumulative net liability, under in−force policies of municipal bond insurance, in an amount which exceeds the sum of:

1. Its capital and surplus, plus

2. The contingency reserve under sub. (9).

(d) A municipal bond insurer may not have more than 25% of the principal amount which it has insured represented by the principal amount of municipal bonds issued primarily to finance property for use in a trade or business carried on by any person other than a governmental unit, and secured by a pledge of payments to be made by the person or of revenues to be derived from the trade or business.

(6) PREMIUM. The total consideration charged for municipal bond insurance policies, including policy and other fees or similar charges, shall be considered premium and shall be subject to the reserve requirements of subs. (8) and (9).

(7) FINANCIAL STATEMENTS AND REPORTING. (a) The financial condition and operations of a municipal bond insurer shall be reported on the annual statement.

(b) The total contingency reserve required by sub. (9) shall be reported as a liability in the annual statement. This liability may be reported as unpaid losses or other appropriately labeled write−in item. Appropriate entries shall be made in the underwriting and investment exhibit—statement of income of the annual statement. The change in contingency reserve for the year shall be reported in the annual statement as a reduction of or a deduction from underwriting income. If the contingency reserve is recorded as a loss liability, the change in the reserve shall be excluded from loss development similar to fidelity and surety losses incurred but not reported.

(c) A municipal bond insurer shall compute and maintain adequate case basis loss reserves to be reported in the underwriting and investment exhibit, unpaid losses and loss adjustment expenses, of the annual statement. The method used to determine the loss reserve shall accurately reflect loss frequency and loss severity and shall include components for claims reported and unpaid, and for claims incurred but not reported, provided:

1. No deduction may be made for anticipated salvage in computing case basis loss reserves.

2. If the amount of insured principal and interest on a defaulted issue of municipal bonds which is due and payable over the period of the next 3 years exceeds 10% of a municipal bond insurer's capital, surplus and contingency reserve, its case basis reserve so established shall be supported by a report from a qualified independent source.

(8) UNEARNED PREMIUM RESERVE. A municipal bond insurer shall compute and maintain an unearned premium reserve on an annual or on a monthly pro rata basis on all unexpired coverage, except that in the case of premiums paid more than one year in advance, the premium shall be earned proportionally with the expiration of exposure except as provided under sub. (12).

(9) CONTINGENCY RESERVE. (a) A municipal bond insurer shall establish a contingency reserve which shall consist of allocations of sums representing 50% of the earned premium on policies of municipal bond insurance except as provided under sub. (12).

(b) The contingency reserve established by this subsection shall be maintained for 240 months. That portion of the contingency reserve established and maintained for more than 240 months shall be released and may no longer constitute part of the contingency reserve except as provided under sub. (12).

(c) Subject to the approval of the commissioner, withdrawals may be made from the contingency reserve in any year in which the actual incurred losses on municipal bond insurance policies exceed 35% of the earned premiums on municipal bonds insurance policies except as provided under sub. (12).

(d) A municipal bond insurer may invest the contingency reserve in tax and loss bonds purchased pursuant to 26 USC 832(e). The contingency reserve shall otherwise be invested only in classes of securities or types of investments specified in s. 620.22 (1), Stats., except as provided under sub. (12).

(10) CONFLICTS OF INTEREST PROHIBITED. No municipal bond insurer may pay any commission or make any gift of money, property or other valuable thing to any employee, agent, or representative of any issuer of municipal bonds or to any employee, agent or representative of any underwriter of any issue of the bonds as an inducement to the purchase of, or at any time there is in force, a policy insuring bonds, and no employee, agent or representative of the insurer or underwriter shall receive any payment or gift. However, violation of the provisions of this subsection does not render void the municipal bond insurance policy.

(11) TRANSITION. Unearned premium reserves and contingency loss reserves shall be computed and maintained on risks insured after the effective date of this section as required by subs. (8) and (9).

(12) LAWS OR REGULATIONS OF OTHER JURISDICTIONS. Whenever the laws or regulations of another jurisdiction in which a municipal bond insurer is licensed, require a larger unearned premium reserve or a larger contingency reserve in the aggregate than that set forth in this section, the establishment and maintenance of the larger aggregated, unearned premium reserve and contingency reserve complies with this rule.

History: Emerg. cr. eff. 6−5−84; cr. Register, October, 1984, No. 346, eff. 11−1−84; am. (3) (d) intro., (5) (c) and (9) (c), Register, March, 1986, No. 363, eff. 4−1−86; correction in (3) (a) made under s. 13.93 (2m) (b) 7., Stats., Register, July, 1999, No. 523.

Ins 3.09 Mortgage guaranty insurance. (1) PURPOSE. This section implements and interprets s. Ins 6.75 (2) (i) and (j) and ss. 601.01, 601.42, 611.19 (1), 611.24, 618.21, 620.02, 623.02, 623.03, 623.04, 623.11, 627.05 and 628.34 (12), Stats., for the purpose of establishing minimum requirements for the transaction of mortgage guaranty insurance.

(2) SCOPE. This rule shall apply to the underwriting, investment, marketing, rating, accounting and reserving activities of insurers which write the type of insurance authorized by s. Ins 6.75 (2) (i) and (j).

(3) DEFINITIONS. (a) "Amount at risk" means the coverage percentage or the claim settlement option percentage multiplied by the face of amount of a mortgage or by the insured amount of a lease.

(b) "Annual statement" means the fire and casualty annual statement form specified in s. Ins 7.02, Forms 22−010 and 22−011.

(c) "Contingency reserve" means the reserve established for the protection of policyholders against the effect of losses resulting from adverse economic cycles.

(d) "Equity" means the complement of the Loan−to−Value.

(e) "Face amount" means the entire indebtedness under an insured mortgage before computing any reduction because of an insurer's option limiting its coverage.

(f) "Loan−to−value" means the ratio of the entire indebtedness to value of the collateral property expressed as a percentage.

(g) "Mortgage guaranty account" means the portion of the Contingency Reserve which complies with 26 USC 832 (e) as amended.

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(h) "Mortgage guaranty insurance" means that kind of insurance authorized by s. Ins 6.75 (2) (i).

(i) "Mortgage guaranty insurer" means an insurer which:

1. Insures pursuant to s. Ins 6.75 (2) (i), or

2. Insures pursuant to s. Ins 6.75 (2) (j) against loss arising from failure of debtors to meet financial obligations to creditors under evidences of indebtedness secured by a junior lien or charge on real estate.

(j) "Mortgage guaranty insurers report of policyholders position" means the annual supplementary report required by s. Ins 7.02, Forms 22−090 and 22−091.

(k) "NAIC Ratio—Investment Yield" means net investment income earned after taxes from the annual statement divided by mean invested assets.

(L) "Person" means any individual, corporation, association, partnership or any other legal entity.

(m) "Policyholders position" includes the contingency reserve established under sub. (14), the deferred risk charge established under sub. (13) (b) and surplus as regards policyholders. "Minimum policyholders position" is calculated as described in sub. (5).

(n) "Surplus as regards policyholders" means an insurer's net worth, the difference between its assets and liabilities, as reported in its annual statement.

(4) DISCRIMINATION. No mortgage guaranty insurer may discriminate in the issuance or extension of mortgage guaranty insurance on the basis of the geographic location of the property or the applicant's sex, marital status, race, color, creed or national origin.

(5) MINIMUM POLICYHOLDERS POSITION. (a) For the purpose of complying with s. 623.11, Stats., a mortgage guaranty insurer shall maintain at all times a minimum policyholders position in the amount required by this section. The policyholders position shall be net of reinsurance ceded but shall include reinsurance assumed.

(b) If a mortgage guaranty insurer does not have the minimum amount of policyholders position required by this section it shall cease transacting new business until such time that its policyholders position is in compliance with this section.

(c) If a policy of mortgage guaranty insurance insures individual loans with a percentage claim settlement option on such loans, a mortgage guaranty insurer shall maintain a policyholders position based on: each $100 of the face amount of the mortgage; the percentage coverage; and the loan−to−value category. The minimum amount of policyholders position shall be calculated in the following manner:

1. If the loan−to−value is greater than 75%, the minimum policyholders position per $100 of the face amount of the mortgage for the specific percent coverage shall be as shown in the schedule below:

Percent Coverage	Policyholders Position Per $100 of the Face Amount of the Mortgage	Percent Coverage	Policyholders Position Per $100 of the Face Amount of the Mortgage
5	$0.20	55	$1.50
10	0.40	60	1.55
15	0.60	65	1.60
20	0.80	70	1.65
25	1.00	75	1.75
30	1.10	80	1.80
35	1.20	85	1.85
40	1.30	90	1.90
45	1.35	95	1.95
50	1.40	100	2.00

2. If the loan−to−value is at least 50% and not more than 75%, the minimum amount of the policyholders position shall be 50% of the minimum of the amount calculated under subd. 1.

3. If the loan−to−value is less than 50%, the minimum amount of policyholders position shall be 25% of the amount calculated under subd. 1.

(d) If a policy of mortgage guaranty insurance provides coverage on a group of loans subject to an aggregate loss limit, the policyholders position shall be:

1. If the equity is not more than 50% and is at least 20%, or equity plus prior insurance or a deductible is at least 25% and not more than 55%, the minimum amount of policyholders position shall be calculated as follows:

Percent Coverage	Policyholders Position Per $100 of the Face Amount of the Mortgage	Percent Coverage	Policyholders Position Per $100 of the Face Amount of the Mortgage
1	$0.30	50	$0.825
5	0.50	60	0.85
10	0.60	70	0.875
15	0.65	75	0.90
20	0.70	80	0.925
25	0.75	90	0.95
30	0.775	100	1.00
40	0.80		

2. If the equity is less than 20%, or the equity plus prior insurance or a deductible is less than 25%, the minimum amount of policyholders position shall be 200% of the amount required by subd. 1.

3. If the equity is more than 50%, or the equity plus prior insurance or a deductible is more than 55%, the minimum amount of policyholders position shall be 50% of the amount required by subd. 1.

(e) If a policy of mortgage guaranty insurance provides for layers of coverage, deductibles or excess reinsurance, the minimum amount of policyholders position shall be computed by subtraction of the minimum position for the lower percentage coverage limit from the minimum position for the upper or greater coverage limit.

(f) If a policy of mortgage guaranty insurance provides for coverage on loans secured by junior liens, the policyholders position shall be:

1. If the policy provides coverage on individual loans, the minimum amount of policyholders position shall be calculated as in par. (c) as follows:

a. The loan−to−value percent is the entire loan indebtedness on the property divided by the value of the property;

b. The percent coverage is the insured portion of the junior loan divided by the entire loan indebtedness on the collateral property; and

c. The face amount of the insured mortgage is the entire loan indebtedness on the property.

2. If the policy provides coverage on a group of loans subject to an aggregate loss limit, the policyholders position shall be calculated according to par. (d) as follows:

a. The equity is the complement of the loan−to−value percent calculated as in subd. 1.;

b. The percent coverage is calculated as in subd. 1.; and

c. The face amount of the insured mortgage is the entire loan indebtedness on the property.

(g) If a policy of mortgage guaranty insurance provides for coverage on leases, the policyholders position shall be $4 for each $100 of the insured amount of the lease.

(h) If a policy of mortgage guaranty insurance insures loans with a percentage loss settlement option coverage between any of the entries in the schedules in this subsection, then the factor for policyholders position per $100 of the face amount of the mortgage shall be prorated between the factors for the nearest Percent Coverage listed.

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(6) LIMITATION ON INVESTMENT. A mortgage guaranty insurer shall not invest in notes or other evidences of indebtedness secured by mortgage or other lien upon real property. This section shall not apply to obligations secured by real property, or contracts for the sale of real property, which obligations or contracts of sale are acquired in the course of the good faith settlement of claims under policies of insurance issued by the mortgage guaranty insurer, or in the good faith disposition of real property so acquired.

(7) LIMITATION ON ASSUMPTION OF RISKS. (a) A mortgage guaranty insurer shall not insure loans secured by properties in a single or contiguous housing or commercial tract in excess of 10% of the insurer's admitted assets. A mortgage guaranty insurer shall not insure a loan secured by a single risk in excess of 10% of the insurer's admitted assets. In determining the amount of such risk or risks, the insurer's liability shall be computed on the basis of its election to limit coverage and net of reinsurance ceded to an insurer authorized to transact such reinsurance in this state. "Contiguous" for the purpose of this subsection means not separated by more than one−half mile.

(b) A mortgage guaranty insurer shall not insure loans with balloon payment provisions unless the policy provides:

1. That liability for the balloon payment is specifically excluded; or

2. That at the time the lender calls the loan, the lender will offer new or extended financing at the then market rates; or

3. The scheduled maturity date of the balloon payment.

(7m) SEGREGATED TRUST REQUIREMENTS. A segregated trust established under this section shall be established by a reinsurer for the benefit of a mortgage guaranty insurer and shall satisfy all of the following requirements:

(a) Has a trustee domiciled in the mortgage guaranty insurer's state of domicile, domiciled in Wisconsin or approved by the commissioner.

(b) Meets the criteria in sub. (12) (g) and (h).

(c) Invests in the type of assets permitted by s. Ins 6.20 (5), or, for the reserves required by subs. (13) and (15), in funds as defined by ch. Ins 52.

(d) Makes quarterly and annual reports as required by the commissioner.

(e) Is subject to withdrawals only by and under the control of the ceding mortgage guaranty insurer.

(f) Permits examinations by the commissioner.

(g) Designates a Wisconsin agent for service of process.

(h) Provides to the commissioner an opinion of counsel stating that the segregated trust and its governing agreements comply with the applicable sections of this section and that the reinsured will have a valid and perfected security interest or an equitable interest in the assets transferred under the trust agreements, or both, and will be entitled to use those assets for the purpose of satisfying a reinsurer's obligations under the trust agreement in the event of the bankruptcy of the reinsurer.

(i) Is governed by an agreement which, together with all amendments, has been approved by the commissioner.

(8) REINSURANCE. (a) A mortgage guaranty insurer may, by contract, reinsure any insurance it transacts, except that no mortgage guaranty insurer may enter into reinsurance arrangements designed to circumvent the compensation control provisions of sub. (16) or the contingency reserve requirement of sub. (14). The unearned premium reserve required by sub. (13), the contingency reserve required by sub. (14) and the loss reserve required by sub. (15) shall be established and maintained by the original insurer or by the assuming reinsurer so that the aggregate reserves shall be equal to or greater than the reserves required by subs. (13), (14) and (15).

(b) If reinsurance is assumed by an insurer which insures or reinsures other lines of insurance in addition to mortgage guaranty insurance, then in order for a mortgage guaranty insurer to receive credit for reinsurance ceded in its financial statements and in the calculation of minimum policyholders position, all of the following shall occur:

1. The reinsurance agreement and the segregated account or segregated trust arrangements shall be submitted to the commissioner for approval.

2. The reinsurer shall establish and maintain in a segregated account or segregated trust the reserves required by subs. (13), (14) and (15).

3. If the reinsurer establishes a segregated trust, the reinsurance agreement shall provide that:

a. The segregated trust shall be in a form approved by the commissioner;

b. The commissioner shall approve any amendments to the reinsurance agreement before the amendments become effective;

c. The ceding mortgage guaranty insurer has a right to terminate the ceding of additional insurance under the reinsurance agreement if so ordered by the commissioner;

d. The commissioner has the right to request from the assuming reinsurer information concerning its financial condition; and

e. The assuming reinsurer shall notify the commissioner of any material change in its financial condition.

(c) In reviewing a reinsurance arrangement with an insurer which writes other lines of insurance in addition to mortgage guaranty, the commissioner may consider any or all of the following:

1. The financial condition of the reinsurer and the trustee.

2. The reinsurance agreement and its compliance with this section.

3. The trust agreement and its compliance with this section. After review of the reinsurance and trust agreements, the commissioner may deny credit for the reinsurance on the ceding mortgage guaranty insurer's financial statements, if deemed necessary for the protection of the mortgage guaranty insurer or its Wisconsin insureds.

(9) ADVERTISING. No mortgage guaranty insurer or any agent or representative of a mortgage guaranty insurer shall prepare or distribute or assist in preparing or distributing any brochure, pamphlet, report or any form of advertising to the effect that the real estate investments of any financial institution are "insured investments", unless the brochure, pamphlet, report or advertising clearly states that the loans are insured by insurers possessing a certificate of authority to transact mortgage guaranty insurance in this state or are insured by an agency of the federal government, as the case may be.

(10) POLICY FORMS. All policy forms and endorsements shall be filed with and be subject to approval of the commissioner. With respect to owner−occupied, single−family dwellings, the mortgage guaranty insurance policy shall provide that the borrower shall not be liable to the insurance company for any deficiency arising from a foreclosure sale.

(11) PREMIUM. (a) The total consideration charged for mortgage guaranty insurance policies, including policy and other fees or similar charges, shall be considered premium and must be stated in the policy and shall be subject to the reserve requirements of subs. (13) and (14).

(b) The rate making formula for mortgage guaranty insurance shall contain a factor or loading sufficient to produce the amount required for the contingency reserve prescribed by sub. (14).

(12) REPORTING. (a) The financial condition and operations of a mortgage guaranty insurer shall be reported annually on the annual statement.

(b) The unearned premium reserve required by sub. (13) shall be reported in the underwriting and investment exhibit—recapitulation of all premiums schedule of the annual statement.

(c) The contingency reserve required by sub. (14) shall be reported as a liability in the annual statement. This liability may be reported as unpaid losses, mortgage guaranty account or other

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appropriately labeled write−in item. Appropriate entries shall be made in the underwriting and investment exhibit—statement of income of the annual statement. The change in contingency reserve for the year shall be reported in the annual statement as a reduction of or a deduction from underwriting income. If the contingency reserve is recorded as a loss liability, the change in the reserve shall be excluded from loss development similar to fidelity and surety losses incurred but not reported. The development of the contingency reserve and policyholders position shall be shown in an appropriate supplemental schedule to the annual statement as prescribed by the commissioner.

(d) The loss reserves required by sub. (15) shall be reported in the underwriting and investment exhibit—unpaid losses and loss adjustment schedule of the annual statement.

(e) Any property acquired pursuant to the exercise of the claim settlement option shall be valued net of encumbrances; and an aggregate amount of such property may be held as is permitted for nonlife insurer investments pursuant to s. 620.22 (5), Stats.

(f) Expenses shall be recorded and reported in accordance with ss. Ins 6.30 and 6.31.

(g) An insurer which writes mortgage guaranty insurance and any other class of insurance business shall establish a segregated account for mortgage guaranty insurance. An insurer which writes more than one class of mortgage guaranty insurance shall establish a segregated account for each class of mortgage guaranty insurance. An insurer which reinsures mortgage guaranty insurance and which writes or reinsures any other class of insurance business shall establish a segregated account or segregated trust for mortgage guaranty reinsurance. The classes of mortgage guaranty insurance are those types of insurance defined in:

1. Section Ins 6.75 (2) (i) 1. a. and c.; or
2. Section Ins 6.75 (2) (i) 1. b. and 2.; or
3. Section Ins 6.75 (2) (i) 1. d. and (j).

(h) Each segregated account or segregated trust established to comply with par. (g) shall contain all of the following applicable reserves:

1. The loss reserves required by sub. (15).
2. The unearned premium reserve required by sub. (13) or (18).
3. The contingency reserve required by sub. (14) or (18) or any surplus required by the commissioner.

(13) UNEARNED PREMIUM RESERVE. Subject to sub. (8), a mortgage guaranty insurer shall compute and maintain an unearned premium reserve on policies in force as follows:

(a) For premium plans on which the premium is paid annually, the unearned premium reserve shall be calculated on either an annual or monthly pro rata basis except that the portion of the first−year premium, excluding policy and other fees or similar charges, which exceeds twice the subsequent renewal premium rate, shall be considered a deferred risk premium. The deferred risk premium shall be contributed to and maintained in the unearned premium reserve until released as earned. The deferred risk premium shall be earned in accordance with the factors for a 10−year premium period in par. (b) or any other formula approved by the commissioner.

(b) For premium plans on which the premium is paid in advance for periods of time greater than one year but less than 16 years, the unearned premium reserve shall be calculated by multiplying the premiums collected by the appropriate unearned premium factor from the table set forth below:

UNEARNED PREMIUM FACTOR TO BE APPLIED TO PREMIUMS COLLECTED

Contract Year Current at Valuation Date	2−Year Premium Period	3−Year Premium Period	4−Year Premium Period	5−Year Premium Period	6−Year Premium Period	7−Year Premium Period	8−Year Premium Period
1	89.0%	93.7%	95.3%	96.0%	96.4%	96.6%	96.8%
2	39.0%	65.0%	73.6%	77.6%	79.8%	81.1%	82.0%
		21.3%	40.6%	49.6%	54.5%	57.5%	59.4%
			12.3%	25.5%	32.7%	37.2%	40.1%
				7.6%	16.5%	22.1%	25.7%
					4.9%	11.2%	7.8%
						3.3%	2.3%

Contract Year Current at Valuation Date	9−Year Premium Period	10−Year Premium Period	11−Year Premium Period	12−Year Premium Period	13−Year Premium Period	14−Year Premium Period	15−Year Premium Period
1	96.9%	97.0%	97.5%	97.1%	97.2%	97.3%	97.3%
2	82.6%	83.2%	83.7%	84.0%	84.4%	84.7%	85.0%
3	60.9%	62.2%	63.3%	64.1%	64.9%	65.6%	66.1%
4	42.3%	44.1%	45.8%	47.1%	48.2%	49.1%	49.9%
5	28.4%	30.7%	32.8%	34.4%	35.8%	36.9%	37.9%
6	18.5%	21.1%	23.4%	25.2%	26.9%	28.0%	29.2%
7	11.3%	14.1%	16.7%	18.6%	20.4%	21.7%	23.0%
8	6.1%	9.1%	11.8%	13.8%	15.8%	17.1%	18.5%
9	2.0%	5.2%	7.9%	10.0%	12.1%	13.4%	14.9%
10		1.7%	4.4%	6.7%	8.8%	10.2%	11.8%
11			1.4%	3.8%	5.9%	7.4%	9.0%
12				1.2%	3.3%	5.0%	6.6%
13					1.1%	2.8%	4.4%
14						.9%	2.5%
15							.8%

Note: For purposes of this calculation, premiums collected means either 90% of the premiums collected or the premium collected less a dollar amount or percentage amount approved by the commissioner to represent initial expenses of selling and issuing a new policy.

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(c) For premium plans on which the premium is paid in advance for periods of 16 years or more, the unearned premium reserve shall be calculated either by a method approved by the commissioner or by dividing the premium collected, as defined above in par. (b), into 2 parts. The first part shall be the amount which is equal to the premium collected for a 15−year premium and which shall be earned in the same manner as a 15−year premium. The second part is the remaining amount of premium in excess of the 15−year premium, which shall be earned pro rata over the remaining term of the premium.

(14) CONTINGENCY RESERVE. (a) Subject to sub. (8), a mortgage guaranty insurer shall make an annual contribution to the contingency reserve which in the aggregate shall be the greater of:

1. 50% of the net earned premium reported in the annual statement; or

2. The sum of:

a. The policyholders position established under sub. (5) on residential buildings designed for occupancy by not more than four families divided by 7;

b. The policyholders position established under sub. (5) on residential buildings designed for occupancy by 5 or more families divided by 5;

c. The policyholders position established under sub. (5) on buildings occupied for industrial or commercial purposes divided by 3; and

d. The policyholders position established under sub. (5) for leases divided by 10.

(b) If the mortgage guaranty coverage is not expressly provided for in this section, the commissioner may establish a rate formula factor that will produce a contingency reserve adequate for the risk assumed.

(c) The contingency reserve established by this subsection shall be maintained for 120 months. That portion of the contingency reserve established and maintained for more than 120 months shall be released and shall no longer constitute part of the contingency reserve.

(d) 1. With the approval of the commissioner, withdrawals may be made from the contingency reserve when incurred losses and incurred loss expenses exceed the greater of either 35% of the net earned premium or 70% of the amount which par. (a) requires to be contributed to the contingency reserve in such year.

2. On a quarterly basis, provisional withdrawals may be made from the contingency reserve in an amount not to exceed 75% of the withdrawal calculated in accordance with subd. 1.

(e) With the approval of the commissioner, a mortgage guaranty insurer may withdraw from the contingency reserve any amounts which are in excess of the minimum policyholders position. In reviewing a request for withdrawal pursuant to this paragraph, the commissioner may consider loss development and trends. If any portion of the contingency reserve for which withdrawal is requested pursuant to this paragraph is maintained by a reinsurer, the commissioner may also consider the financial condition of the reinsurer. If any portion of the contingency reserve for which withdrawal is requested pursuant to this paragraph is maintained in a segregated account or segregated trust and such withdrawal would result in funds being removed from the segregated account or segregated trust, the commissioner may also consider the financial condition of the reinsurer.

(f) Releases and withdrawals from the contingency reserve shall be accounted for on a first−in−first−out basis as provided in sub. (12) (g).

(g) The calculations to develop the contingency reserve shall be made in the following sequence:

1. The additions required by pars. (a) and (b);

2. The releases permitted by par. (c);

3. The withdrawals permitted by par. (d); and

4. The withdrawals permitted by par. (e).

(15) LOSS RESERVES. (a) Subject to sub. (8), a mortgage guaranty insurer shall compute and maintain adequate loss reserves. The methodology used for computing the loss reserves shall accurately reflect loss frequency and loss severity and shall include components for claims reported and unpaid and for claims incurred but not reported.

(b) A mortgage guaranty insurer shall compute and maintain adequate case basis loss reserves which are based on an estimate of the liability for claims on individual insured loans in various stages of default as listed below. Case basis loss reserves may be calculated on either an individual case basis or a formula basis. Case basis loss reserves shall be established for individual insured loans or leases which:

1. Are in default and have resulted in the collateral real estate being acquired by the insured, the insurer, or the agent of either, and remaining unsold; or

2. Are in the process of foreclosure; or

3. Are in default and the insurer has received notification.

(c) In computing the potential liability for which case basis reserves are required by par. (b), the following factors shall be considered together with the prospective adjustments reflecting historic data relative to prior claim settlements:

1. Prior to the exercise of the claim settlement option, the potential liability shall be either the amount at risk calculated using the coverage settlement option or the potential claim amount minus the value of the real estate.

2. If the claim settlement option exercised results in recording the claim amount as the cost of acquisition of the property, the potential liability is the claim amount minus the lesser of the market value of the real estate or the acquisition cost of the real estate.

3. If the claim settlement option exercised results in the payment of amounts equal to the monthly loan payments or lease rents, the potential liability is the present value, utilizing the insurer's National Association of Insurance Commissioners' (NAIC) financial ratio−investment yield, of the claim amounts minus the present value of either the real estate or the rental income stream.

(d) A mortgage guaranty insurer shall compute and maintain a loss adjustment expense reserve which is based on an estimate of the cost of adjusting and settling claims on insured loans in default.

(e) A mortgage guaranty insurer shall compute and maintain an incurred but not reported reserve which is based on an estimate of the liability for future claims on insured loans that are in default but of which the insurer has not been notified.

(16) CHARGES, COMMISSIONS AND REBATES. (a) Every mortgage guaranty insurer shall adopt, print and make available a schedule of premium charges for mortgage guaranty insurance coverages. The schedule shall show the entire amount of premium charge for each type of mortgage guaranty insurance coverage issued by the insurer.

(b) A mortgage guaranty insurer shall not knowingly pay, either directly or indirectly to an owner, purchaser, mortgagee of the real property or any interest therein or to any person who is acting as agent, representative, attorney or employee of such owner, purchaser, or mortgagee any commission, remuneration, dividend or any part of its premium charges or any other consideration as an inducement for or as compensation on any mortgage guaranty insurance business.

(c) In connection with the placement of any insurance, a mortgage guaranty insurer shall not cause or permit any commission, fee, remuneration, or other compensation to be paid to, or received by: any insured lender; any subsidiary or affiliate of any insured; any officer, director or employee of any insured; any member of their immediate family; any corporation, partnership, trust, trade association in which any insured is a member, or other entity in which any insured or any such officer, director, or employee or any member of their immediate family has a financial interest; or

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any designee, trustee, nominee, or other agent or representative of any of the foregoing.

(d) A mortgage guaranty insurer shall not make any rebate of any portion of the premium charge shown by the schedule required by par. (a). A mortgage guaranty insurer shall not quote any premium charge to any person which is different than that currently available to others for the same type of mortgage guaranty insurance coverage sold by the mortgage guaranty insurer. The amount by which any premium charge is less than that called for by the current schedule of premium charge is a rebate.

(e) A mortgage guaranty insurer shall not use compensating balances, special deposit accounts or engage in any practice which unduly delays its receipt of monies due or which involves the use of its financial resources for the benefit of any owner, mortgagee of the real property or any interest therein or any person who is acting as agent, representative, attorney or employee of such owner, purchaser or mortgagee as a means of circumventing any part of this rule. Except for commercial checking accounts and normal deposits in support of an active bank line of credit, any deposit account bearing interest at rates less than is currently being paid other depositors on similar deposits or any deposit in excess of amounts insured by an agency of the federal government shall be presumed to be an account in violation of this paragraph.

(f) A mortgage guaranty insurer shall make provision for prompt refund of any unearned premium in the event of termination of the insurance prior to its scheduled termination date. If the borrower paid or was charged for the premium, the refund shall be made to the borrower, or to the insured for the borrower's benefit, otherwise refund may be paid to the insured.

(g) This subsection is not intended to prohibit payment of appropriate policy dividends to borrowers.

(17) MINIMUM CAPITAL OR PERMANENT SURPLUS. The minimum amount of capital or permanent surplus of a mortgage guaranty insurer shall be $2 million for an insurer first authorized to do business in Wisconsin on or after January 1, 1982, or the amount required by statute or administrative order before that date or other insurers.

(18) TRANSITION. Policyholders position, unearned premium reserves and contingency loss reserves shall be computed and maintained on risks insured after the effective date of this section as required by subs. (5), (13) and (14). Unearned premium reserves and contingency loss reserves on risks insured before the effective date of this rule may be computed and maintained either as required by subs. (13) and (14) or as required by this section as previously in effect.

(19) CONFLICT OF INTEREST. (a) Except as described in par. (c), if a member of a holding company system as defined in s. Ins 40.01 (6), a mortgage guaranty insurer licensed to transact insurance in this state shall not, as a condition of its certificate of authority, knowingly underwrite mortgage guaranty insurance on mortgages originated by the holding company system or an affiliate or on mortgages originated by any mortgage lender to which credit is extended, directly or indirectly by the holding company system or affiliate.

(b) A mortgage guaranty insurer, the holding company system of which it is a part or any affiliate shall not as a condition of the mortgage guaranty insurer's certificate of authority, pay any commissions, remuneration, rebates or engage in activities proscribed in sub. (15).

(c) 1. A mortgage guaranty insurer may underwrite mortgage guaranty insurance on mortgages originated by the holding company system or affiliate or on mortgages originated by any mortgage lender to which credit is extended, directly or indirectly by the holding company system or affiliate only if the insurance is underwritten on the same basis, for the same consideration and subject to the same insurability requirements as insurance provided to nonaffiliated lenders. Mortgage guaranty insurance underwritten on mortgages originated by the holding company system or affiliate or on mortgages originated by any mortgage lender to which credit is extended, directly or indirectly by the holding company system or affiliate shall be limited to 50% of the insurer's direct premium written in any calendar year, or such higher percentage established in writing for the insurer in the commissioner's discretion, based on the commissioner's determination that a higher percentage is not likely to adversely affect the financial condition of the insurer.

2. A domestic mortgage guaranty insurer that offers coverage under subd. 1., shall annually file by March 1 a certification executed by a senior, responsible officer that the insurer has complied with subd. 1. in the previous calendar year. The commissioner may grant an extension to an insurer if the commissioner determines an extension is not likely to materially impede the office's monitoring of the insurer's compliance with this subsection.

(20) LAWS OR REGULATIONS OF OTHER JURISDICTIONS. Whenever the laws or regulations of another jurisdiction in which a mortgage guaranty insurer subject to the requirements of this rule is licensed, require a larger unearned premium reserve or a larger contingency reserve in the aggregate than that set forth in this rule, the establishment and maintenance of the larger unearned premium reserve or contingency reserve shall be deemed to be compliance with this rule.

(21) This section may be enforced under ss. 601.41, 601.64, 601.65, Stats., or ch. 645, Stats., or any other enforcement provision of chs. 600 to 646, Stats.

History: Cr. Register, March, 1957, No. 15, eff. 4−1−57; am. (2), (3), (4) and (5), Register, January, 1959, No. 37, eff. 2−1−59; am. (4) (c), Register, August, 1959, No. 44, eff. 9−1−59; cr. (4) (e), Register, January, 1961, No. 61, eff. 2−1−61; am. (2), Register, January, 1967, No. 133, eff. 2−1−67; am. (2), (3) (a) and (b), and (4) (a) and (b); r. and recr. (5), Register, December, 1970, No. 180, eff. 1−1−71. r. and recr. Register, March, 1975, No. 231, eff. 4−1−75; emerg. am. (1), (2) and (3) (a), eff. 6−22−76; am. (1), (2) and (3) (a), Register, September, 1976, No. 249, eff. 10−1−76; am. (1), (2) and (3) (a), Register, March, 1979, No. 279, eff. 4−1−79; r. and recr. (1), (3), (5), (12) and (14), am. (2), (4), (8), (13) (a) and (16), renum. (7) to be (7) (a) and cr. (7) (b) and (7m), Register, October, 1982, No. 322, eff. 11−1−82; correction in (14) (d) made under s. 13.93 (2m) (b) 7., Stats., Register, December, 1984, No. 348; am. (3) (m), Register, October, 1985, No. 358, eff. 11−1−85; am. (1) and (5) (a), renum. (7m), (15) to (18) to be (17), (16) and (18) to (20); cr. (7m) and (15), r. and recr. (8), (12) to (14), Register, November, 1989, No. 407, eff. 12−1−89; correction in (7m) (c) made under s. 13.93 (2m) (b) 7., Stats., Register, January, 1999, No. 517; corrections in (3) (b), (j) and (19) made under s. 13.93 (2m) (b) 7., Stats., Register, July, 1999, No. 523; am. (19) (a), cr. (19) (c), Register, July, 2000, No. 535, eff. 8−1−00; CR 05−023: am. (19) (c) and cr. (21) Register December 2005 No. 600, eff. 1−1−06.

Ins 3.11 Multiple peril insurance contracts. (1) PURPOSE AND SCOPE. (a) This rule implements and interprets s. Ins 6.70 and chs. 625 and 631, Stats., by enumerating the minimum requirements for the writing of multiple peril insurance contracts. Nothing herein contained is intended to prohibit insurers or groups of insurers from justifying rates or premiums in the manner provided for by the rating laws.

(b) This rule shall apply to multiple peril insurance contracts permitted by s. Ins 6.70, and which include a type or types of coverage or a kind or kinds of insurance subject to ch. 625, Stats.

(c) Types of coverage or kinds of insurance which are not subject to ch. 625, Stats., or to the filing requirement provisions thereof, may not be included in multiple peril insurance contracts otherwise subject to said sections unless such entire multiple peril insurance contract is filed as being subject to this rule and said sections and the filing requirements thereof.

(2) DEFINITION. Multiple peril insurance contracts are contracts combining 2 or more types of coverage or kinds of insurance included in any one or more than one paragraph of s. Ins 6.75. Such contracts may be on the divisible or single (indivisible) rate or premium basis.

(3) RATE MAKING. (a) When underwriting experience is not available to support a filing, the information set forth in s. 625.12, Stats., may be furnished as supporting information.

(b) Premiums or rates may be modified for demonstrated, measurable, or anticipated variation from normal of the loss or expense experience resulting from the combination or types of coverage or kinds of insurance or other factors of the multiple peril

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insurance contract. Multiple peril contracts may be filed or revised on the basis of sufficient underwriting experience developed by the contract or such experience may be used in support of such filing.

(c) In the event that more than one rating organization cooperates in a single (indivisible) rate or premium multiple peril insurance filing, one of such cooperating rating organizations shall be designated as the sponsoring organization for such filing by each of the other cooperating rating organizations and evidence of such designation included with the filing.

(4) STANDARD POLICY. The requirements of s. Ins 6.76 shall apply to any multiple peril insurance contract which includes insurance against loss or damage by fire.

History: Cr. Register, July, 1958, No. 31, eff. 8−1−58; am. (3) (a), Register, November, 1960, No. 59, eff. 12−1−60; emerg. am. (1), (2), (3) (a) and (4), eff. 6−22−76; am. (1), (2), (3) (a) and (4), Register, September, 1976, No. 249, eff. 10−1−76; am. (1) (a) and (b), (2) and (4), Register, March, 1979, No. 279, eff. 4−1−79.

Ins 3.13 Individual accident and sickness insurance. (1) PURPOSE. This section implements and interprets applicable statutes for the purpose of establishing procedures and requirements to expedite the review and approval of individual accident and sickness policies permitted by s. Ins 6.75 (1) (c) or (2) (c), and franchise type accident and sickness policies permitted by s. 600.03 (22), Stats., and s. Ins 6.75 (1) (c) and (2) (c). The requirements in subs. (2), (3), (4) and (6) are to be followed in substance, and wording other than that described may be used provided it is not less favorable to the insured or beneficiary.

(2) POLICY PROVISIONS. (a) If a policy is not to insure against sickness losses resulting from conditions in existence prior to the effective date of coverage, or in existence prior to a specified period after such effective date, the policy by its terms shall indicate that it covers sickness contracted and commencing (or beginning, or originating, or first manifested or words of similar import) after such effective date or after such specified period. Wording shall not be used that requires the cause of the condition or sickness, as distinguished from the condition or sickness itself, to originate after such effective date or such specified period.

Note: It is understood that "sickness" as used herein means the condition or disease from which the disability or loss results. Paragraph (a) shall not apply to nor prohibit the exclusion from coverage of a disease or physical condition by name or specific description.

(b) Where any "specified period" referred to in par. (a) exceeds 30 days, it shall apply to the occurrence of loss and not to the contracting or commencement of sickness after such period.

(c) A policy, other than a non−cancellable policy or a non−cancellable and guaranteed renewable policy or a guaranteed renewable policy, shall set forth the conditions under which the policy may be renewed, either by: A *brief description* of the policy's renewal conditions, or a separate statement referring to the policy's renewal conditions, or a separate appropriately captioned renewal provision appearing on or commencing on the first page.

1. The *brief description*, if used to meet the foregoing requirement, shall be printed, in type more prominent than that used in the policy's text, at the top or bottom of the policy's first page and on its filing back, if any, and shall describe its renewal conditions in one of the following ways: "Renewal Subject to Consent of Company", "Renewal Subject to Company Consent", "Renewal at Option of Company", "Renewal at Option of Company as Stated in _____" (refer to appropriate policy provision), or "Renewal May be Refused as Stated in _____" (refer to appropriate policy provision). A company may submit other wording, subject to approval by the commissioner, which it believes is equally clear or more definite as to subject matter.

2. The *separate statement*, if used to meet the foregoing requirement, shall be printed, in type more prominent than that used in the policy's text, at the top or bottom of the policy's first page and on its filing back, if any, and shall describe its renewal conditions in one of the following ways: "Renewal Subject to Consent of Company", "Renewal Subject to Company Consent", "Renewal at Option of Company", "Renewal at Option of Company as Stated in _____" (refer to appropriate policy provision), or "Renewal May be Refused as Stated in _____" (refer to appropriate policy provision). A company may submit other wording, subject to approval by the commissioner, which it believes is equally clear or more definite as to subject matter.

3. The *renewal provision* appearing on or commencing on the policy's first page, if used to meet the foregoing requirement, shall be preceded by a caption which describes the policy's renewal conditions in one of the following ways: "Renewal Subject to Consent of Company", "Renewal Subject to Company Consent", "Renewal at Option of Company", "Renewal at Option of Company as Stated Below", or "Renewal May be Refused as Stated Herein". A company may submit other wording, subject to approval by the commissioner, which it believes is equally clear or more definite as to subject matter. The caption shall be in type more prominent than that used in the policy's text.

(d) If the policy is not renewable, it shall be so described in the brief description or in a separate statement at the top or bottom of the first page and on the filing back, if any, or it shall be so described in a separate appropriately captioned provision on the first page. The brief description, or the separate statement, or the caption shall be printed in type more prominent than that used in the policy's text.

(e) 1. The terms "non−cancellable" or "non−cancellable and guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums set forth in the policy:

a. Until at least age 50, or

b. In the case of a policy issued after age 44, for at least 5 years from its date of issue, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force.

2. A non−cancellable or non−cancellable and guaranteed renewable policy form shall disclose, as prominently as and in close conjunction with any prominent use of the terms "non−cancellable" or "non−cancellable and guaranteed renewable":

a. The age to or term for which the form is non−cancellable or non−cancellable and guaranteed renewable, if other than lifetime,

b. The age or time at which the form's benefits are reduced, if applicable, (The age or time at which a form's benefits are reduced need not be so disclosed if such reduction is not effected prior to the age to or term for which the form is non−cancellable or non−cancellable and guaranteed renewable or if regular benefits are payable at least to the age to or term for which the form is non−cancellable or non−cancellable and guaranteed renewable.) and

c. That benefit payments are subject to an aggregate limit, if applicable.

3. Except as provided above, the term "guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums:

a. Until at least age 50, or

b. In the case of a policy issued after age 44, for at least 5 years from its date of issue, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes.

4. A guaranteed renewable policy form shall disclose, as prominently as and in close conjunction with any prominent use of the term "guaranteed renewable":

a. The age to or term for which the form is guaranteed renewable, if other than lifetime,

b. The age or time at which the form's benefits are reduced, if applicable, (The age or time at which a form's benefits are

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reduced need not be so disclosed if such reduction is not effected prior to the age to or term for which the form is guaranteed renewable or if regular benefits are payable at least to the age to or term for which the form is guaranteed renewable.)

c. That benefit payments are subject to an aggregate limit, if applicable, and

d. That the applicable premium rates may be changed.

Note: "Prominent use" as referred to in subds. 2. and 4. is considered to include, but is not necessarily limited to, use in titles, brief descriptions, captions, bold−face type, or type larger than that used in the text of the form.

5. The foregoing limitation on the use of the term "non−cancellable" shall also apply to any synonymous term such as "not cancellable" and the limitation on use of the term "guaranteed renewable" shall apply to any synonymous term such as "guaranteed continuable".

6. Nothing herein contained is intended to restrict the development of policies having other guarantees of renewability, or to prevent the accurate description of their terms of renewability or the classification of such policies as guaranteed renewable or non−cancellable for any period during which they may actually be such, provided the terms used to describe them in policy contracts and advertising are not such as may readily be confused with the above terms.

7. The provisions of ss. 632.76 (1), 632.74 and 632.77 (3), Stats., are applicable to non−cancellable or non−cancellable and guaranteed renewable or guaranteed renewable policy forms as herein defined.

(f) Policies issued on a family basis shall clearly set forth the conditions relating to termination of coverage of any family member.

(g) Surgical benefit provisions or schedules shall provide that the benefit for any covered surgical procedure not specifically listed in the schedule and not excluded by the provisions of the policy shall be determined by the company on a basis consistent with the benefit provided for a comparable listed procedure.

(h) A limited policy is one that contains unusual exclusions, limitations, reductions, or conditions of such a restrictive nature that the payments of benefits under such policy are limited in frequency or in amounts. All limited policies shall be so identified by having the words "THIS IS A LIMITED POLICY—READ IT CAREFULLY" imprinted or stamped diagonally across the face of the policy and the filing back, if any, in contrasting color from the text of the policy and in outline type not smaller than 18−point. When appropriate, these words may be varied by the insurer in a manner to indicate the type of policy; as for example, "THIS POLICY IS LIMITED TO AUTOMOBILE ACCIDENTS—READ IT CAREFULLY". Without limiting the general definition above, policies of the following types shall be defined as "limited": 1. School Accident, 2. Aviation Accident, 3. Polio, 4. Specified Disease, 5. Automobile Accident.

(i) If the policy excepts coverage while the insured is in military or naval service, the policy must provide for a refund of pro rata unearned premium upon request of the insured for any period the insured is not covered. However, if coverage is excluded only for loss resulting from military or naval service or war, the refund provision will not be required. This section shall not apply to non−cancellable policies or non−cancellable and guaranteed renewable policies or guaranteed renewable policies.

(j) Except as provided in s. Ins 3.39 (7) (d), the provision or notice regarding the right to return the policy required by s. 632.73, Stats., shall:

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

2. Have a caption or title which refers at least to the right to examine or to return the policy such as: "Right to Return Policy Within 10 Days of Receipt", "Notice: Right to Return Policy", "Right of Policy Examination", "Right to Examine Policy", "Right to Examine Policy for 10 Days", "10 Day Right to Examine Policy", "10 Day Right to Return Policy", or "Notice of 10 Day Right to Return Policy", or other wording, subject to approval by the commissioner, which is believed to be equally clear or more definite as to subject matter, and

3. Provide an unrestricted right to return the policy, within 10 days from the date it is received by the policyholder, to the issuer at its home or branch office, if any, or to the agent through whom it was purchased; except it shall provide an unrestricted right to return the policy within 30 days of the date it is received by the policyholder in the case of a Medicare supplement policy subject to s. Ins 3.39 (4), (4s), (5), (5m), and (6), issued pursuant to a direct response solicitation. Provision shall not be made to require the policyholder to set out in writing the reasons for returning the policy, to require the policyholder to first consult with an agent of the issuer regarding the policy, or to limit the reasons for return.

Note: Paragraph (j) was adopted to assist in the application of s. 204.31 (2) (a), Stats., to the review of accident and sickness policy and other contract forms. Those statutory requirements are presently included in s. 632.73, Stats. The original statute required that the provision of notice regarding the right to return the policy must be appropriately captioned or titled. Since the important rights given the insured are to examine the policy and to return the policy, the rule requires that the caption or title must refer to at least one of these rights—examine or return. Without such reference, the caption or title is not considered appropriate.

The original statute permitted the insured to return the policy for refund to the home office or branch office of the insurer or to the agency with whom it was purchased. In order to assure the refund is made promptly, some insurers prefer to instruct the insured to return the policy to a particular office or agent for a refund. Notices or provisions with such requirements will be approved on the basis that the insurer must recognize an insured's right to receive a full refund if the policy is returned to any other office or agent mentioned in the statute.

Also, the statute permits the insured to return a policy for refund within 10 days from the date of receipt. Some insurers' notices or provisions regarding such right, however, refer to delivery to the insured instead of receipt by the insured or do not specifically provide for the running of the 10 days from the date the insured receives the policy. Notices or provisions containing such wording will be approved on the basis that the insurer will not refuse refund if the insured returns the policy within 10 days from the date of receipt of the policy.

Sections 632.73 (2m) and 600.03 (35) (e), as created by Chapter 82, Laws of 1981, provide for the right of return provisions in certain certificates of group Medicare supplement policies. Therefore, for purposes of this subparagraph, the word policy includes a Medicare supplement certificate subject to s. Ins 3.39 (4), (5), and (6).

(k) A policy which contains any provision under which the claimant may elect one benefit in lieu of another shall not limit to a specified period the time within which election may be made.

(3) RIDERS AND ENDORSEMENTS. (a) A rider is an instrument signed by one or more officers of the insurer issuing the same to be attached to and form a part of a policy. All riders shall comply with the requirements of s. 204.31 (2) (a) 4., 1973 Stats.

(b) If the rider reduces or eliminates coverage of the policy, signed acceptance of the rider by the insured is necessary. However, signed acceptance of the rider is not necessary when the rider is attached at the time of the original issuance of the policy if notice of the attachment of the rider is affixed on the face and filing back, if any, in contrasting color, in not less than 12−point type. Such notice shall be worded in one of the following ways:

"Notice! See Elimination Rider Attached"

"Notice! See Exclusion Rider Attached"

"Notice! See Exception Rider Attached"

"Notice! See Limitation Rider Attached"

A company may submit, subject to approval by the commissioner, other wording which it believes is equally clear or more definite as to subject matter.

(c) An endorsement differs from a rider only in that it is applied to a policy by means of printing or stamping on the body of the policy. All endorsements shall comply with the requirements of s. 204.31 (2) (a) 4., 1973 Stats.

(d) If the endorsement reduces or eliminates coverage of the policy, signed acceptance of the endorsement by the insured is necessary. However, signed acceptance of the endorsement is not necessary when the endorsement is affixed at the time of the original issuance of the policy if notice of the endorsement is affixed on the face and filing back, if any, in contrasting color, in not less than 12−point type. Such notice shall be worded in one of the following ways:

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"Notice! See Elimination Endorsement Included Herein"

"Notice! See Exclusion Endorsement Included Herein"

"Notice! See Exception Endorsement Included Herein"

"Notice! See Limitation Endorsement Included Herein"

"Notice! See Reduction Endorsement Included Herein"

A company may submit, subject to approval by the commissioner, other wording which it believes is equally clear or more definite as to subject matter.

(4) APPLICATIONS. (a) Application forms shall meet the requirements of s. Ins 3.28 (3).

(b) It shall not be necessary for the applicant to sign a proxy provision as a condition for obtaining insurance. The applicant's signature to the application must be separate and apart from any signature to a proxy provision.

(c) The application form, or the copy of it, attached to a policy shall be plainly printed or reproduced in light−faced type of a style in general use, the size of which shall be uniform and not less than 10−point.

(6) RATE FILINGS. (a) The following must be accompanied by a rate schedule:

1. Policy forms.

2. Rider or endorsement forms which affect the premium rate.

(b) The rate schedule shall bear the insurer's name and shall contain or be accompanied by the following information:

1. The form number or identification symbol of each policy, rider or endorsement to which the rates apply.

2. A schedule of rates including policy fees or rate changes at renewal, if any, variations, if any, based upon age, sex, occupation, or other classification.

3. An indication of the anticipated loss ratio on an earned−incurred basis.

4. Any revision of a rate filing shall be accompanied by a statement of the experience on the form and the anticipated loss ratio on an earned−incurred basis under the revised rate filing.

5. Subdivisions 3. and 4. shall not apply to non−cancellable policies or riders or non−cancellable and guaranteed renewable policies or riders or guaranteed renewable policies or riders.

History: Cr. Register, March, 1958, No. 27; subsections (1), (5), (6) eff. 4−1−58; subsections (2), (3), (4) eff. 5−15−58; am. (2) (c) and cr. (4) (c), Register, March, 1959, No. 39, eff. 4−1−59; am. (2) (e), (6) (b) 3. and 4., Register, November, 1959, No. 47, eff. 12−1−59; am. and renum. (2) (c), (d), (e), (f), (g) and (h); am. (3) and (6) (b) 5., Register, June, 1960, No. 54, eff. 7−1−60; am. (2) (e) 4., Register, November, 1960, No. 59, eff. 12−1−60; r. (2) (j), Register, April, 1963, No. 88, eff. 5−1−63; cr. (2) (j), Register, March, 1964, No. 99, eff. 4−1−64; am. (2) (e) 2. and 4., Register, April, 1964, No. 100, eff. 5−1−64; am. (2) (j) 2.; am. NOTE in (2) (j) 3; Register, March, 1969, No. 159; eff. 4−1−69; cr. (2) (k), Register, June, 1971, No. 186, eff. 7−1−71; am. (4) (a), Register, February, 1974, No. 218, eff. 3−1−74; emerg. am. (1), (2) (e) 7., (2) (j), (3) (a) and (c), eff. 6−22−76; am. (1), (2) (e) 7., (2) (j), (3) (a) and (c), Register, September, 1976, No. 249, eff. 10−1−76; am. (1) and (2) (e) 7, Register, March, 1979, No. 279, eff. 4−1−79; r. (5), Register, January, 1980, No. 289, eff. 2−1−80; am. (2) (j) 3., Register, June, 1982, No. 318, eff. 7−1−82; emerg. am. (2) (j) and cr. (2) (jm), eff. 11−19−85; am. (2) (j) (intro.) and cr. (2) (jm), Register, March, 1986, No. 363, eff. 4−1−86; am. (1), Register, September, 1986, No. 369, eff. 10−1−86; emerg. am. (2) (j) (intro.), renum. (2) (jm) to be Ins 3.39 (7) (d), eff. 1−1−92; am. (2) (j) (intro.), renum. (2) (jm) to be Ins 3.39 (7) (d), Register, July, 1992, No. 439, eff. 8−1−92; correction in (1) made under s. 13.93 (2m) (b) 7., Stats., Register, January, 1999, No. 517; CR 08−112: am. (2) (j) 3. Register June 2009 No. 642, eff. 7−1−09.

Ins 3.14 Group accident and sickness insurance. **(1)** PURPOSE. This rule implements and interprets applicable statutes for the purpose of establishing procedures and requirements to expedite the review and approval of group accident and sickness policies permitted by s. 600.03 (23), Stats., and s. Ins 6.75 (1) (c) or (2) (c).

(3) RATE FILINGS. Schedules of premium rates shall be filed in accordance with the requirements of ch. 601, Stats., and s. 631.20, Stats. The schedules of premium rates shall bear the insurer's name and shall identify the coverages to which such rates are applicable.

(4) CERTIFICATES. (a) Each certificate issued to an employee or member of an insured group in connection with a group insurance policy shall include a statement in summary form of the provisions of the group policy relative to:

1. The essential features of the insurance coverage,

2. To whom benefits are payable,

3. Notice or proof of loss,

4. The time for paying benefits, and

5. The time within which suit may be brought.

(5) COVERAGE REQUIREMENTS. (a) Policies issued in accordance with s. 600.03 (23), Stats., shall offer to insure all eligible members of the group or association except any as to whom evidence of insurability is not satisfactory to the insurer. Cancellation of coverage of individual members of the group or association who have not withdrawn participation nor received maximum benefits is not permitted, except that the insurer may terminate or refuse renewal of an individual member who attains a specified age, retires or who ceases to actively engage in the duties of a profession or occupation on a full−time basis or ceases to be an active member of the association or labor union or an employee of the employer, or otherwise ceases to be an eligible member.

(b) Surgical benefit provisions or schedules shall provide that the benefit for any covered surgical procedure not specifically listed in the schedule and not excluded by the provisions of the policy shall be determined by the company on a basis consistent with the benefit provided for a comparable listed procedure.

(c) A policy which contains any provision under which the claimant may elect one benefit in lieu of another shall not limit to a specified period the time within which election may be made.

(6) ELIGIBLE GROUPS. In accordance with s. 600.03 (23), Stats.:

(a) The members of the board of directors of a corporation are eligible to be covered under a group accident and sickness policy issued to such corporation,

(b) The individual members of member organizations of an association, as defined in s. 600.03 (23), Stats., are eligible to be covered under a group accident and sickness policy issued to such association insuring employees of such association and employees of member organizations of such association, and

(c) The individuals supplying raw materials to a single processing plant and the employees of such processing plant are eligible to be covered under a group accident and sickness policy issued to such processing plant.

History: Cr. Register, March, 1958, No. 27; subsections (1), (2), (3), eff. 4−1−58; subsections (4), (5), eff. 5−1−58; renum. (5) to be (5) (a); cr. (5) (b), Register, November, 1959, No. 47, eff. 12−1−59; am. (1) (3), (5) (a) and cr. (6), Register, October, 1961, No. 70, eff. 11−1−61; am. (6), Register, February, 1962, No. 74, eff. 3−1−62; cr. (5) (c), Register, June, 1971, No. 186, eff. 7−1−71; emerg. am. (1), (3), (5) (a), (6) (intro.) and (6) (b), eff. 6−22−76; am. (1), (3), (5) (a), (6) (intro.) and (6) (b), Register, September, 1976, No. 249, eff. 10−1−76; r. (2), Register, January, 1980, No. 289, eff. 2−1−80; am. (1), (5) (a), (6) (intro.) and (b), Register, September, 1986, No. 369, eff. 10−1−86; correction in (5) (a) made under s. 13.93 (2m) (b) 5., Stats., Register, April, 1992, No. 436.

Ins 3.15 Blanket accident and sickness insurance. **(1)** PURPOSE. This rule implements and interprets applicable statutes for the purpose of establishing procedures and requirements to expedite the review and approval of blanket accident and sickness policies permitted by s. 600.03 (4), Stats., and s. Ins 6.75 (1) (c) or (2) (c).

(3) RATE FILINGS. Schedules of premium rates shall be filed in accordance with the requirements of ch. 601, Stats., and s. 631.20, Stats. The schedules of premium rates shall bear the insurer's name and shall identify the coverages to which such rates are applicable.

(4) ELIGIBLE RISKS. (a) In accordance with the provisions of s. 600.03 (4), Stats., the following are eligible for blanket accident and health insurance: 1. Volunteer fire departments, 2. National guard units, 3. Newspaper delivery carriers, 4. Dependents of students, 5. Volunteer civil defense organizations, 6. Volunteer auxiliary police organizations, 7. Law enforcement agencies, 8. Coop-

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eratives organized under ch. 185, Stats., on a membership basis without capital stock, 9. Registered guests in a motel, hotel, or resort, 10. Members or members and advisors of fraternal organizations including women's auxiliaries of such organizations and fraternal youth organizations, 11. Associations of sports officials, 12. Purchasers of protective athletic equipment, 13. Migrant workers, 14. Participants in racing meets, 15. Patrons or guests of a recreational facility or resort.

(b) A company may submit any other risk or class of risks, subject to approval by the commissioner, which it believes is properly eligible for blanket accident and health insurance.

(5) COVERAGE REQUIREMENTS. (a) Surgical benefit provisions or schedules shall provide that the benefit for any covered surgical procedure not specifically listed in the schedule and not excluded by the provisions of the policy shall be determined by the company on a basis consistent with the benefit provided for a comparable listed procedure.

(b) A policy which contains any provision under which the claimant may elect one benefit in lieu of another shall not limit to a specified period the time within which election may be made.

History: Cr. Register, March, 1958, no. 27, eff. 4−1−58; am. (4) (a), cr. (5), Register, November, 1959, No. 47, eff. 12−1−59; am. (1), (3) and (4) (a), Register, October, 1961, No. 70, eff. 11−1−61; am. (4) (a), Register, April, 1963, No. 88, eff. 5−1−63; am. (4) (a), Register, June, 1963, No. 90, eff. 7−1−63; am. (4) (a), Register, October, 1963, No. 94, eff. 11−1−63; am. (4) (a), Register, August, 1964, No. 104, eff. 9−1−64; am. (4) (a), Register, August, 1968, No. 152, eff. 9−1−68; am. (4) (a), Register, March, 1969, No. 159, eff. 4−1−69; am. (4) (a), Register, August, 1970, No. 176, eff. 9−1−70; am. (4) (a), renum. (5) to be (5) (a), and cr. (b), Register, June, 1971, No. 186, eff. 7−1−71; emerg. am. (1), (3) and (4) (a), eff. 6−22−76; am. (1), (3) and (4) (a), Register, September, 1976, No. 249, eff. 10−1−76; r. (2), Register, January, 1980, No. 289, eff. 2−1−80; am. (1), Register, September, 1986, No. 369, eff. 10−1−86; corrections to (4) made under s. 13.93 (2m) (b) 5. and 7., Stats., Register, April, 1992, No. 436.

Ins 3.17 Reserves for accident and sickness insurance policies. (1) PURPOSE. This section establishes required minimum standards under ch. 623, Stats., for claim, premium and contract reserves of insurers writing accident and sickness insurance policies.

(2) SCOPE. This section applies to any insurer, including a fraternal benefit society, issuing a policy providing individual or group accident and sickness insurance coverages as classified under s. Ins 6.75 (1) (c) or (2) (c). This section does not apply to credit insurance as classified under s. Ins 6.75 (1) (c) 1. or (2) (c) 1.

(3) DEFINITIONS. In this section:

(a) "Annual claim cost" means the net annual cost per unit of benefit before the addition of expenses, including claim settlement expenses, and a margin for profit or contingencies.

Note: For example, the annual claim cost for a $100 monthly disability benefit, for a maximum disability benefit period of one year, with an elimination period of one week, with respect to a male at age 35, in a certain occupation might be $12, while the gross premium for this benefit might be $18. The additional $6 would cover expenses and profit or contingencies.

(b) "Claims accrued" means that portion of claims incurred on or prior to the valuation date which result in liability of the insurer for the payment of benefits for medical services which have been rendered on or prior to the valuation date, and for the payment of benefits for days of hospitalization and days of disability which have occurred on or prior to the valuation date, which the insurer has not paid as of the valuation date, but for which it is liable, and will have to pay after the valuation date.

Note: This liability is sometimes referred to as a liability for accrued benefits. A claim reserve, which represents an estimate of this accrued claim liability, must be established.

(c) "Claims incurred" means a claim for which the insurer has become obligated to make payment, on or prior to the valuation date.

(d) "Claims reported" means those claims that have been incurred on or prior to the valuation date of which the insurer has been informed, on or prior to the valuation date.

Note: These claims are considered as reported claims for annual statement purposes.

(e) "Claims unaccrued" means that portion of claims incurred on or prior to the valuation date which result in liability of the insurer for the payment of benefits for medical services expected to be rendered after the valuation date, and for benefits expected to be payable for days of hospitalization and days of disability occurring after the valuation date.

Note: This liability is sometimes referred to as a liability for unaccrued benefits. A claim reserve, which represents an estimate of the unaccrued claim payments expected to be made (which may or may not be discounted with interest), must be established.

(f) "Claims unreported" means those claims that have been incurred on or prior to the valuation date of which the insurer has not been informed, on or prior to the valuation date.

Note: These claims are considered as unreported claims for annual statement purposes.

(g) "Date of disablement" means the earliest date on which the insured is considered as being disabled under the definition of disability in the contract, based on a physician's evaluation or other evidence.

(h) "Elimination period" means a specified number of days, weeks, or months starting at the beginning of each period of loss, during which no benefits are payable.

(i) "Gross premium" means the amount of premium charged by the insurer. It includes the net premium, based on claim cost, for the risk together with any loading for expenses, profit or contingencies.

(j) "Group insurance" includes blanket insurance.

(k) "Individual insurance" includes franchise insurance.

(L) "Level premium" means a premium calculated to remain unchanged throughout either the lifetime of the policy, or for some shorter projected period of years.

Note: The level premium need not be guaranteed; in which case, although it is calculated to remain level, it may be changed if any of the assumptions on which it was based are revised at a later time.

Generally, the annual claim costs are expected to increase each year and the insurer, instead of charging premiums that correspondingly increase each year, charges a premium calculated to remain level for a period of years or for the lifetime of the contract. In this case the benefit portion of the premium is more than needed to provide for the cost of benefits during the earlier years of the policy and less than the actual cost in the later years. The building of a prospective contract reserve is a natural result of level premiums.

(m) "Modal premium" means the premium paid on a contract based on a premium term which could be annual, semiannual, quarterly, monthly, or weekly.

Note: Thus if the annual premium is $100 and if, instead, monthly premiums of $9 are paid then the modal premium is $9.

(n) "Negative reserve" means a negative terminal reserve value due to the values of the benefits decreasing with advancing age or duration.

(o) "Preliminary term reserve method" means the method of valuation under which the valuation net premium for each year falling within the preliminary term period is exactly sufficient to cover the expected incurred claims of that year, so that the terminal reserve will be zero at the end of the year. As of the end of the preliminary term period, a new constant valuation net premium, or stream of changing valuation premiums, becomes applicable such that the present value of all such premiums is equal to the present value of all claims expected to be incurred following the end of the preliminary term period.

(p) "Present value of amounts not yet due on claims" means the reserve for claims unaccrued which may be discounted at interest.

(q) "Reserve" includes all items of benefit liability, whether in the nature of incurred claim liability or in the nature of contract liability relating to future periods of coverage, and whether the liability is accrued or unaccrued.

Note: An insurer under its contracts promises benefits which result in:

On claims incurred, payments expected to be made after the valuation date for accrued and unaccrued benefits are liabilities of the insurer which should be provided for by establishing claim reserves; or

Claims which are expected to be incurred after the valuation date. Any present liability of the insurer for these future claims should be provided for by the establishment of contract reserves and unearned premium reserves.

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(r) "Terminal reserve" means the reserve at the end of the contract year which is the present value of benefits expected to be incurred after that contract year minus the present value of future valuation net premiums.

(s) "Unearned premium reserve" means that portion of the premium paid or due to the insurer which is applicable to the period of coverage extending beyond the valuation date.

Note: Thus if an annual premium of $120 was paid on November 1, $20 would be earned as of December 31 and the remaining $100 would be unearned. The unearned premium reserve could be on a gross basis as in this example, or on a valuation net premium basis.

(t) "Valuation net modal premium" means the modal fraction of the valuation net annual premium that corresponds to the gross modal premium in effect on any contract to which contract reserves apply. Thus if the mode of payment in effect is quarterly, the valuation net modal premium is the quarterly equivalent of the valuation net annual premium.

(4) RESERVES IN EXCESS OF MINIMUM RESERVE STANDARDS. An insurer subject to this section may determine that the adequacy of its accident and sickness reserves requires reserves in excess of the minimum standards specified in this section. The insurer shall hold and consider the excess reserves as its minimum reserves.

(5) PROSPECTIVE GROSS PREMIUM VALUATION. (a) With respect to any block of contracts, or with respect to an insurer's accident and sickness business as a whole, a prospective gross premium valuation is the ultimate test of reserve adequacy as of a given valuation date. The gross premium valuation shall take into account, for contracts in force, in a claims status, or in a continuation of benefits status on the valuation date, the present value as of the valuation date adjusted for future premium increases reasonably expected to be put into effect, of:

1. All expected benefits unpaid.

2. All expected expenses unpaid.

3. All unearned or expected premiums.

(b) The insurer shall perform a gross premium valuation whenever a significant doubt exists as to reserve adequacy with respect to any major block of contracts, or with respect to the insurer's accident and sickness business as a whole. In the event inadequacy is found to exist, the insurer shall make immediate loss recognition and restore the reserves to adequacy. The insurer shall hold adequate reserves, inclusive of claim, premium and contract reserves, if any, with respect to all contracts, regardless of whether contract reserves are required for the contracts under these standards.

(c) Whenever minimum reserves, as defined in these standards, exceed reserve requirements as determined by a prospective gross premium valuation, the minimum reserves remain the minimum requirement under these standards.

(6) CLAIM RESERVES. (a) General claim reserve requirements are:

1. Claim reserves are required for all incurred but unpaid claims on all accident and sickness insurance policies;

2. Appropriate claim expense reserves are required with respect to the estimated expense of settlement of all incurred but unpaid claims; and

3. The insurer shall test reserves for prior valuation years for adequacy and reasonableness along the lines of claim run−off schedules in accordance with the statutory financial statement including consideration of any residual unpaid liability.

(b) Minimum standards for claim reserves are as follows:

1. For disability income:

a. The maximum interest rate for claim reserves is specified in Appendix A;

b. Minimum standards with respect to morbidity are those specified in Appendix A; except that, at the option of the insurer, for claims with a duration from date of disablement of less than two years, the insurer may base the reserves on the insurer's experience, if the experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities;

c. For contracts with an elimination period, the insurer shall measure the duration of disablement as dating from the time that benefits would have begun to accrue had there been no elimination period.

2. For all other benefits:

a. The maximum interest rate for claim reserves is specified in Appendix A;

b. The insurer shall base the reserve on the insurer's experience, if this experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities;

(c) General claim reserve methods are as follows:

1. The insurer may use any generally accepted or reasonable actuarial method or combination of methods to estimate all claim liabilities.

2. The methods used for estimating liabilities generally may be aggregate methods, or various reserve items may be separately valued. The insurer may also employ approximations based on groupings and averages. The insurer shall, however, determine adequacy of the claim reserves in the aggregate.

(7) PREMIUM RESERVES. (a) General premium reserve requirements are:

1. Unearned premium reserves are required for all contracts with respect to the period of coverage for which premiums, other than premiums paid in advance, have been paid beyond the date of valuation;

2. If premiums due and unpaid are carried as an asset, the insurer shall treat the premiums as premiums in force, subject to unearned premium reserve determination. The insurer shall carry as an offsetting liability the value of unpaid commissions, premium taxes, and the cost of collection associated with due and unpaid premiums; and

3. Insurers may appropriately discount to the valuation date the gross premiums paid in advance for a period of coverage commencing after the next premium due date which follows the date of valuation. The insurer shall hold this discounted premium either as a separate liability or as an addition to the unearned premium reserve which would otherwise be required as a minimum.

(b) Minimum standards for unearned premium reserves are as follows:

1. The minimum unearned premium reserve with respect to any contract is the pro rata unearned modal premium that applies to the premium period beyond the valuation date, with the premium determined on the basis of:

a. The valuation net modal premium on the contract reserve basis applying to the contract; or

b. The gross modal premium for the contract if no contract reserve applies.

2. However, the sum of the unearned premium and contract reserves for all contracts of the insurer subject to contract reserve requirements may not be less than the gross modal unearned premium reserve on all of the contracts, as of the date of valuation. To the extent not provided for elsewhere in this section, this reserve may not be less than the expected claims for the period beyond the valuation date represented by the unearned premium reserve.

(c) General premium reserve methods are as follows:

1. In computing premium reserves, the insurer may employ suitable approximations and estimates; including, but not limited to, groupings, averages and aggregate estimation.

2. The insurer shall periodically test the approximations or estimates to determine their continuing adequacy and reliability.

(8) CONTRACT RESERVES. (a) General contract reserve requirements are:

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1. Contract reserves are required, unless otherwise specified in subd. 2. for:

a. All individual and group contracts with which level premiums are used; or

b. All individual and group contracts with respect to which, due to the gross premium pricing structure at issue, the value of the future benefits at any time exceeds the value of any appropriate future valuation net premiums at that time. The insurer shall determine the values specified in this subparagraph on the basis specified in par. (b);

2. Contracts not requiring a contract reserve are:

a. Contracts which cannot be continued after one year from issue; or

b. Contracts already in force on the effective date of these standards for which no contract reserve was required under the immediately preceding standards;

3. The contract reserve is in addition to claim reserves and premium reserves; and

4. The insurer shall use methods and procedures for contract reserves that are consistent with those for claim reserves for any contract, or else shall make appropriate adjustment when necessary to assure provision for the aggregate liability. The insurer shall use the same definition of the date of incurral in both determinations.

(b) The basis for determining minimum standards for contract reserves are:

1. Minimum standards with respect to morbidity are those set forth in Appendix A. Valuation net premiums used under each contract shall have a structure consistent with the gross premium structure at issue of the contract as this relates to advancing age of insured, contract duration and period for which gross premiums have been calculated. The insurer shall value contracts for which tabular morbidity standards are not specified in Appendix A using tables established for reserve purposes by a qualified actuary meeting the requirements of s. Ins 6.12 and acceptable to the commissioner;

Note: The consistency between the gross premium structure and the valuation net premium is required only at issue, because the impact on the consistency after issue of regulatory restrictions on premium rate increases is still under study.

2. The maximum interest rate is specified in Appendix A;

3. The insurer shall use termination rates in the computation of reserves on the basis of a mortality table as specified in Appendix A except as noted in the following paragraph.

3m. Under contracts for which premium rates are not guaranteed, and where the effects of insurer underwriting are specifically used by policy duration in the valuation morbidity standard, the insurer may use total termination rates at ages and durations where these exceed specified mortality table rates, but not in excess of the lesser of:

a. Eighty percent of the total termination rate used in the calculation of the gross premiums, or

b. Eight percent.

3s. Where a morbidity standard specified in Appendix A is on an aggregate basis, the insurer may adjust the morbidity standard to reflect the effect of insurer underwriting by policy duration. The adjustments shall be appropriate to the underwriting and acceptable to the commissioner;

4. The minimum reserve is the reserve calculated on the two−year full preliminary term method; that is, under which the terminal reserve is zero at the first and also the second contract anniversary. The insurer may apply the two−year preliminary term method only in relation to the date of issue of a contract. The insurer shall apply reserve adjustments introduced later, as a result of rate increases, revisions in assumptions or for other reasons, immediately as of the effective date of adoption of the adjusted basis;

5. The insurer may offset negative reserves on any benefit against positive reserves for other benefits in the same contract, but the total contract reserve with respect to all benefits combined may not be less than zero.

(c) Provided the contract reserve on all contracts to which an alternative method or basis is applied is not less in the aggregate than the amount determined according to the applicable standards specified in this section; an insurer may use any reasonable assumptions as to interest rates, termination or mortality rates or both, and rates of morbidity or other contingency. Also, subject to the preceding sentence, the insurer may employ methods other than the methods stated in this section in determining a sound value of its liabilities under the contracts, including, but not limited to the following:

1. The net level premium method;

2. The one−year full preliminary term method;

3. Prospective valuation on the basis of actual gross premiums with reasonable allowance for future expenses;

4. The use of approximations such as those involving age groupings, groupings of several years of issue, average amounts of indemnity, grouping of similar contract forms;

5. The computation of the reserve for one contract benefit as a percentage of, or by other relation to, the aggregate contract reserves exclusive of the benefit or benefits so valued; and

6. The use of a composite annual claim cost for all or any combination of the benefits included in the contracts valued.

(d) 1. Annually, the insurer shall make an appropriate review of the insurer's prospective contract liabilities on contracts valued by tabular reserves, to determine the continuing adequacy and reasonableness of the tabular reserves giving consideration to future gross premiums. The insurer shall make appropriate increments to the tabular reserves if the tests indicate that the basis of the reserves is no longer adequate. Any appropriate increments to tabular reserves made by the insurer under this paragraph shall comply with the minimum standards of par. (b).

2. If an insurer has a contract or a group of related similar contracts, for which future gross premiums will be restricted by the commissioner, the contract, or some other reason, such that the future gross premiums reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims, the insurer shall establish contract reserves for the shortfall in the aggregate.

(9) DETERMINATION OF ADEQUACY. The insurer shall determine the adequacy of its accident and health insurance reserves on the basis of the claim reserves, premium reserves, and contract reserves combined. However, the standards established in this section emphasize the importance of determining appropriate reserves for each of these three reserve categories separately.

(10) REINSURANCE. The insurer shall determine, in a manner consistent with these minimum reserve standards and with all applicable provisions of the reinsurance contracts which affect the insurer's liabilities, increases to, or credits against reserves carried, arising because of reinsurance assumed or reinsurance ceded.

History: Cr. Register, April, 1959, No. 40, eff. 5−1−59; am. (2) (a) and (b), Register, June, 1960, No. 54, eff. 7−1−60; am. (3) (a) and Table 1, Register, October, 1960, No. 58, eff. 11−1−60; r. and recr., Register, January, 1967, No. 133, eff. 2−1−67; emerg. am. to (1) to (6), eff. 6−22−76; am. (1), (2), (3) (intro.), (3) (a), 4. and 5., (3) (e), (4) (intro.), (4) (a), (5) and (6), Register, September, 1976, No. 249, eff. 10−1−76; am. (2), (3) and (5), Register, March, 1979, No. 279, eff. 4−1−79; am. (3) (intro.), (a) 4. and 5. (4) (intro.), (5) (intro.) and (6) (intro.), Register, September, 1986, No. 369, eff. 10−1−86; r. and recr. Register, November, 1989, No. 407, eff. 12−1−89.; correction in (8) (b) made under s. 13.93 (2m) (b) 1., Stats., Register, April, 1992, No. 436.

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Ins 3.17 APPENDIX A

SPECIFIC STANDARDS FOR MORBIDITY, INTEREST AND MORTALITY

I. MORBIDITY

A. Minimum morbidity standards for valuation of specified individual contract accident and sickness insurance benefits are as follows:

(1) Disability income benefits due to accident or sickness.

(a) Contract reserves:

Contracts issued on or after January 1, 1968, and prior to January 1, 1987:

The 1964 Commissioners Disability Table (64 CDT)

Contracts issued on or after January 1, 1992:

The 1985 Commissioners Individual Disability Tables A (85CIDA); or

The 1985 Commissioners Individual Disability Tables B (85CIDB).

Contracts issued during 1987 through 1991:

Optional use of either the 1964 Table or the 1985 Tables.

Each insurer shall elect, with respect to all individual contracts issued in any one statement year, whether it will use Tables A or Tables B as the minimum standard. The insurer may, however, elect to use the other tables with respect to contracts issued in any subsequent statement year.

(b) Claim reserves:

The minimum morbidity standard in effect for contract reserves on currently issued contracts, as of the date the claim is incurred.

(2) Hospital benefits, surgical benefits and maternity benefits (scheduled benefits or fixed time period benefits only).

(a) Contract reserves:

Contracts issued on or after January 1, 1955, and before January 1, 1987:

The 1956 Intercompany Hospital−Surgical Tables.

Contracts issued on or after January 1, 1992:

The 1974 Medical Expense Tables, Table A, Transactions of the Society of Actuaries, Volume XXX, pg. 63. Refer to the paper (in the same volume, pg. 9) to which this table is appended, including its discussions, for methods of adjustment for benefits not directly valued in Table A: "Development of the 1974 Medical Expense Benefits," Houghton and Wolf.

Contracts issued during 1987 through 1991:

Optional use of either the 1956 Intercompany Tables or the 1974 Medical Expense Tables.

(b) Claim reserves:

No specific standard. See (5).

(3) Cancer expense benefits (scheduled benefits or fixed time period benefits only).

(a) Contract reserves:

Contracts issued on or after January 1, 1992:

The 1985 NAIC Cancer Claim Cost Tables.

Contracts issued during 1986 through 1991:

Optional use of the 1985 NAIC Cancer Claim Cost Tables.

(b) Claim reserves:

No specific standard. See (5).

(4) Accidental death benefits.

(a) Contract reserves:

Contracts issued on or after January 1, 1992:

The 1959 Accidental Death Benefits Table.

Contracts issued during 1965 through 1991:

Optional use of the 1959 Accidental Death Benefits Tables.

(b) Claim reserves:

Actual amount incurred.

(5) Other individual contract benefits.

(a) Contract reserves:

For all other individual contract benefits, morbidity assumptions are to be determined as provided in the reserve standards.

(b) Claim reserves:

For all benefits other than disability, claim reserves are to be determined as provided in the standards.

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B. Minimum morbidity standards for valuation of specified group contract accident and health insurance benefits are as follows:

(1) Disability income benefits due to accident or sickness.

(a) Contract reserves:

Contracts issued prior to January 1, 1989:

The same basis, if any, as that employed by the insurer as of January 1, 1989.

Contracts issued on or after January 1, 1992:

The 1987 Commissioners Group Disability Income Table (87CGDT).

Contracts issued during 1989 through 1991:

Optional use of the 1989 standard or the 1987 CGDT.

(b) Claim reserves:

For claims incurred on or after January 1, 1992:

The 1987 Commissioners Group Disability Income Table (87CGDT).

For claims incurred prior to January 1, 1987:

The 1964 Commissioners Disability Table (64CDT).

For claims incurred during 1987 through 1991:

Optional use of either the 1964 Table or the 1987 Table.

(2) Other group contract benefits.

(a) Contract reserves:

For all other group contract benefits, morbidity assumptions are to be determined as provided in the reserve standards.

(b) Claim reserves:

For all benefits other than disability, claim reserves are to be determined as provided in the standards.

II. INTEREST

A. For contract reserves the maximum interest rate is the maximum rate permitted by law in the valuation of whole life insurance issued on the same date as the accident and sickness insurance contract.

B. For claim reserves the maximum interest rate is the maximum rate permitted by law in the valuation of whole life insurance issued on the same date as the claim incurral date.

III. MORTALITY

The mortality basis used shall be according to a table (but without use of selection factors) permitted by law for the valuation of whole life insurance issued on the same date as the accident and sickness insurance contract.

Note: The tables referenced in this Appendix may be found as follows:

The 1964 Commissioners Disability Table, 1965 Proceedings of the National Association of Insurance Commissioners, Vol. I, pgs. 78−80.

The 1985 Commissioners Individual Disability Tables A, 1986 Proceedings of the National Association of Insurance Commissioners, Vol. I, pgs. 574−589.

The 1985 Commissioners Individual Disability Tables B, 1985 Proceedings of the National Association of Insurance Commissioners, Vol. I, pgs. 486−540.

The 1956 Intercompany Hospital−Surgical Tables, 1957 Proceedings of the National Association of Insurance Commissioners, Vol. I, pgs. 83−85.

The 1985 NAIC Cancer Claim Cost Tables, 1986 Proceedings of the National Association of Insurance Commissioners, Vol. I, pgs. 609−623.

The 1959 Accidental Death Benefits Table, Transactions of the Society of Actuaries, Vol. XI, pg. 754.

The 1987 Commissioners Group Disability Income Table, 1987 Proceedings of the National Association of Insurance Commissioners, Vol. II, pgs. 557−619.

Note: Reserves for waiver of premium. Waiver of premium reserves involve several special considerations. First, the disability valuation tables promulgated by the NAIC are based on exposures that include contracts on premium waiver as in−force contracts. Therefore, contract reserves based on these tables are not reserves on "active lives," but rather reserves on contracts "in force." This is true for the 1964 CDT and for both the 1985 CIDA and CIDB tables.

Accordingly, tabular reserves using any of these tables should value reserves on the following basis:

Claim reserves should include reserves for premiums expected to be waived, valuing as a minimum the valuation net premium being waived.

Premium reserves should include contracts on premium waiver as in−force contracts, valuing as a minimum the unearned modal valuation net premium being waived.

Contract reserves should include recognition of the waiver of premium benefit in addition to other contract benefits provided for, valuing as a minimum the valuation net premium to be waived.

If an insurer is, instead, valuing reserves on what is truly an active life table, or if a specific valuation table is not being used but the insurer's gross premiums are calculated on a basis that includes in the projected exposure only those contracts for which premiums are being paid, then it may not be necessary to provide specifically for waiver of premium reserves. Any insurer using the true "active life" basis should carefully consider, however, whether or not additional liability should be recognized on account of premiums waived during periods of disability or during claim continuation.

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Ins 3.18 Total consideration for accident and sickness insurance policies. The total consideration charged for accident and sickness insurance policies must include policy and other fees. Such total consideration charged must be stated in the policy, and shall be subject to the reserve requirements of ch. 623, Stats., and s. Ins 3.17, and must be the basis for computing the amount to be refunded in the event of cancellation of the policy.

History: Cr. Register, May, 1959, No. 41, eff. 6−1−59; emerg. am. eff. 6−22−76; am. Register, September, 1976, No. 249, eff. 10−1−76.

Ins 3.19 Group accident and sickness insurance insuring debtors of a creditor. (1) This rule implements and interprets ss. 204.321 (1) (d) and 206.60 (2), 1973 Stats., with regard to issuance of a group policy of accident and sickness insurance issued to a creditor to insure debtors of a creditor.

(2) A group accident and sickness insurance policy may be issued to a creditor to insure debtors of the creditor if the class or classes of insured debtors meet the requirements of s. 206.60 (2) (a) and (c), 1973 Stats., and such a policy shall be subject to the requirements of such paragraphs in addition to other requirements applicable to group accident and sickness insurance policies.

History: Cr. Register, November, 1959, No. 47, eff. 12−1−59; am. Register, September, 1963, No. 93, eff. 10−1−63; r. (3), Register, February, 1973, No. 206, eff. 3−1−73; emerg. am. (1) and (2), eff. 6−22−76; am. (1) and (2), Register, September, 1976, No. 249, eff. 10−1−76.

Ins 3.20 Substandard risk automobile physical damage insurance for financed vehicles. (1) PURPOSE. In accordance with s. 625.34, Stats., this rule is to accomplish the purpose and enforce the provisions of ch. 625, Stats., in relation to automobile physical damage insurance for substandard risks.

(2) SCOPE. This rule applies to any automobile physical damage insurance policy procured or delivered by a finance company.

(3) DEFINITIONS. (a) "Substandard risk" means an applicant for insurance who presents a greater exposure to loss than that contemplated by commonly used rate classifications as evidenced by one or more of the following conditions:

1. Record of traffic accidents.
2. Record of traffic law violations.
3. Undesirable occupational circumstances.
4. Undesirable moral characteristics.

(b) "Substandard risk rate" means a rate or premium charge that reflects the greater than normal exposure to loss which is assumed by an insurer writing insurance for a substandard risk.

(4) RATES FOR SUBSTANDARD RISKS. (a) Any increased rate charged for substandard risks shall not be excessive, inadequate, or unfairly discriminatory.

(b) It shall be unfairly discriminatory to charge a rate or premium that does not reasonably measure the variation between risks and each risk's exposure to loss.

(c) Classification rates filed for substandard risks may not exceed 150% of the rate level generally in use for normal risks unless the filing also provides for the modification of classification rates in accordance with a schedule which establishes standards for measuring variation in hazards or expense provisions or both.

(5) INSURANCE COVERAGE. (a) The automobile physical damage insurance afforded shall be substantially that customarily in use for normal business.

(b) The applicant shall not be required to purchase more coverage than is customarily necessary to protect the interests of the mortgagee. The issuance of a policy shall not be made contingent on the acceptance by the applicant of unwanted or excessively broad coverages.

(c) Single interest coverage may be issued only when double interest coverage is not obtainable. The applicant must be given the opportunity to procure insurance, and if he or she can procure same within 25 days there shall be no charge for the single interest coverage.

(6) POLICY FORMS. The purchaser must be furnished with a complete policy form clearly setting forth the nature and extent of all coverages and premiums charged therefor.

(7) RATING STATEMENT. No policy written on the basis of a sub−standard risk rate schedule shall be issued unless it contains a statement printed in bold−faced type, preferably in a contrasting color, reading substantially as follows: This policy has been rated in accordance with a special rating schedule filed with the commissioner of insurance providing for higher premium charges than those generally applicable for average risks. If the coverage or premium is not satisfactory, you may secure your own insurance.

History: Cr. Register, March, 1960, No. 51, eff. 4−1−60; emerg. am. (1), eff. 6−22−76; am. (1), Register, September, 1976, No. 249, eff. 10−1−76; correction in (1) and (5) (c) made under s. 13.93 (2m) (b) 5. and 7., Stats., Register, April, 1992, No. 436.

Ins 3.23 Franchise accident and sickness insurance. (1) FRANCHISE GROUP HEADQUARTERS. A franchise group described in s. 600.03 (22), Stats., need not have its headquarters or other executive offices domiciled in Wisconsin.

(2) ACCOUNTING. All premiums paid in connection with franchise accident and sickness insurance on Wisconsin residents shall be reported for annual statement purposes as Wisconsin business and shall be subject to the applicable Wisconsin premium tax.

History: Cr. Register, May, 1964, No. 101, eff. 6−1−64; emerg. am. (1) eff. 6−22−76; am. (1), Register, September, 1976, No. 249, eff. 10−1−76; correction in (1) made under s. 13.93 (2m) (b) 7., Stats., Register, April, 1992, No. 436.

Ins 3.25 Credit life insurance and credit accident and sickness insurance. (1) PURPOSE. The purpose of this section is to assist in the maintenance of a fair and equitable credit insurance market and to ensure that policyholders, claimants and insurers are treated fairly and equitably by providing a system of rate, policy form and operating standards for the transaction of credit life insurance and credit accident and sickness insurance. This section interprets and implements ss. 601.01, 601.415 (9), 601.42, 623.06, 625.11, 625.12, 625.34, 631.20, 632.44 (3) and 632.60, Stats., and chs. 421, 422 and 424, Stats.

(2) SCOPE. (a) This section shall apply to the transaction of credit life insurance as defined in s. Ins 6.75 (1) (a) 1. and s. 632.44, Stats., and subject to ch. 424, Stats., and to the transaction of credit accident and sickness insurance as defined in s. Ins 6.75 (1) (c) 1. and (2) (c) 1. and subject to ch. 424, Stats.

(b) This rule shall be the basis for review of all policy forms, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and riders and the schedules of premium rates to be used in Wisconsin on or after the effective date of the rule for credit life and credit accident and sickness insurance.

(3) DEFINITIONS. In this section:

(a) "Case" means, for credit life insurance, all the credit life insurance of a creditor and, for credit accident and sickness insurance, all of each category of credit accident and sickness insurance of a creditor, as specified in Appendix B, unless some reasonable combination of these categories is approved by the commissioner.

(b) "Case rate" means the maximum premium rate or schedule of premium rates permitted to be charged with respect to the coverage of a creditor. Unless a higher premium rate or schedule of premium rates is approved by the commissioner, the case rate is the prima facie premium rate or schedule of premium rates.

(c) "Creditor" has the meaning set forth in s. 421.301 (16), Stats.

(d) "Experience period" means a time period of consecutive calendar years ending with the most recent full calendar year prior

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to the date of determination of a case rate based on such experience period. The number of years shall be not less than one nor more than three; provided, however, that if the number of years is less than three, the life years exposure in the experience period shall be not less than ten thousand for life insurance and not less than one thousand for accident and sickness insurance.

(e) "Incurred claims" means claims paid during the experience period plus claim reserve at the end of the experience period minus claim reserve at the beginning of the experience period.

(f) "Life years exposure" means the average number of group certificates or individual policies in force during an experience period, without regard to multiple coverage, times the number of years in the experience period.

(g) "Prima facie earned premium" means the premium which would have been earned during the experience period if the prima facie premium rate in effect at the end of the experience period had always been charged. The method of calculation shall be that specified in sub. (13).

(h) "Prima facie loss ratio" means incurred claims divided by prima facie earned premium.

(4) TYPES OF CREDIT LIFE INSURANCE OR CREDIT ACCIDENT AND SICKNESS INSURANCE. No credit life insurance or credit accident and sickness insurance policies shall be issued except:

(a) Individual policies of life insurance issued to debtors on a nonrenewable, nonconvertible term plan;

(b) Individual policies of accident and sickness insurance issued to debtors on a term plan or disability benefit provisions in individual policies of credit life insurance;

(c) Group policies of life insurance issued to creditors providing insurance upon the lives of debtors on a term plan;

(d) Group policies of accident and sickness insurance issued to creditors on a term plan insuring debtors or disability benefit provisions in group credit life insurance policies.

(5) AMOUNT OF CREDIT LIFE AND CREDIT ACCIDENT AND SICKNESS INSURANCE. The amount of credit life insurance and credit accident and sickness insurance shall not exceed the amounts specified in s. 424.208, Stats.

(6) TERM OF CREDIT LIFE INSURANCE AND CREDIT ACCIDENT AND SICKNESS INSURANCE. (a) The term of any credit life insurance or credit accident and sickness insurance shall, subject to acceptance by the insurer, commence on the date when the debtor becomes obligated to the creditor, except that, where a group policy provides coverage with respect to existing obligations, the insurance on a debtor with respect to such indebtedness shall commence on the effective date of the policy.

(b) Where evidence of insurability is required and such evidence is furnished more than 30 days after the date when the debtor becomes obligated to the creditor, the term of the insurance may commence on the date on which the insurance company determines the evidence to be satisfactory, and in such event there shall be an appropriate refund or adjustment of any charge to the debtor for insurance. The term of this insurance shall not extend more than 15 days beyond the scheduled maturity date of indebtedness unless it is extended without additional cost to the debtor or as an incident to a deferral, refinancing or consolidation agreement.

(c) If the indebtedness is discharged due to renewal or refinancing prior to the scheduled maturity date, the insurance in force shall be terminated before any new insurance is issued in connection with the renewed or refinanced indebtedness. In any renewal or refinancing of the indebtedness, the effective date of the coverage of any policy provision shall be deemed to be the first date on which the debtor became insured under the policy covering the indebtedness which was renewed or refinanced. However, this does not apply to an amount or term of indebtedness, exclusive of refinancing charges, in excess of the original indebtedness outstanding at the time of refinancing.

(d) In all cases of termination prior to scheduled maturity, a refund shall be paid or credited as provided in sub. (9).

(7) PROVISIONS OF POLICIES AND CERTIFICATES OF INSURANCE; DISCLOSURE TO DEBTORS. (a) All credit life insurance and credit accident and sickness insurance shall be evidenced by an individual policy, or in the case of group insurance, by a certificate of insurance. The individual policy or group certificate of insurance shall be delivered to the debtor.

(b) Each individual policy or group certificate of credit life insurance or credit accident and sickness insurance shall, in addition to other requirements of the law, set forth:

1. The name and home office address of the insurer;

2. The name or names of the debtor or, in the case of a certificate under a group policy, the identity of the debtor;

3. The premium or charge, if any, to be paid by the debtor. Premiums for credit life insurance and for credit accident and sickness insurance shall be shown separately;

4. A description of the coverage including the amount and term of coverage, and any exceptions, limitations and restrictions;

5. A provision that the benefits shall be paid to the creditor to reduce or extinguish the unpaid indebtedness and that whenever the amount of insurance exceeds the unpaid indebtedness, any excess shall be payable to a beneficiary, other than the creditor named by the debtor, or to the debtor's estate, and

6. A provision that the insurance on any debtor will be cancelled and a refund made if the indebtedness is terminated through prepayment or otherwise, in accordance with sub. (9).

(c) The individual policy or group certificate of insurance shall be delivered to the insured debtor at the time the indebtedness is incurred except as provided in par. (d);

(d) If the individual policy or group certificate of insurance is not delivered to the debtor at the time the indebtedness is incurred, a copy of the application for the policy or a notice of proposed insurance shall:

1. Be delivered to the debtor at the time the indebtedness is incurred;

2. Be signed by the debtor;

3. Set forth the name and home office address of the insurer;

4. Set forth the name or names of the debtor;

5. Set forth the premium or amount of payment by the debtor, if any, separately for credit life insurance and credit accident and sickness insurance; and

6. Set forth the amount, term and a brief description of the coverage provided including all exclusions and exceptions.

(e) The copy of the application or notice of proposed insurance shall also refer exclusively to insurance coverage, and the copy or notice shall be separate and apart from the loan, sale or other credit statement of account, instrument or agreement, unless the information required by par. (d) is prominently set forth in the loan, sale or other credit statement of account, instrument or agreement. Upon acceptance of the insurance by the insurer and within 30 days of the date upon which the indebtedness is incurred, the insurer shall cause the individual policy or group certificate of insurance to be delivered to the debtor. The application or notice of proposed insurance shall state that upon acceptance by the insurer, the insurance shall become effective as provided in sub. (6).

(f) If the named insurer does not accept the risk, the debtor shall receive a policy or certificate of insurance from the substituted insurer, if any, including the information required by par. (b). If the amount of premium is less than that set forth in the notice of proposed insurance an appropriate refund shall be made.

(g) If a contract of insurance provides for a limitation in the amount of coverage related to insurance provided by other contracts in force on the debtor, such limitation shall be explained to the debtor at the time the indebtedness is incurred and shall be acknowledged in writing by the debtor in an instrument separate

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from the individual policy or group certificate. Alternatively, the individual policy or group certificate shall include a brief description or separate statement referring to the limitation in the amount of coverage. The brief description or separate statement, shall be printed on the first page of the individual policy or group certificate in type more prominent than that used in the text of the policy or certificate and shall indicate the limitation clearly.

(h) If a contract of insurance provides for a limitation of coverage related to the age of the debtor, such limitation shall be explained to the debtor at the time the indebtedness is incurred and shall be acknowledged in writing in an instrument separate from the individual policy or group certificate. Alternatively, the individual policy or group certificate shall include a brief description or separate statement referring to the age limitation. The brief description or separate statement, shall be printed on the first page of the individual policy or group certificate in type more prominent than that used in the text of the policy or certificate and shall indicate the limitation clearly.

(i) Conspicuous notice of the debtor's right to return the policy, certificate of insurance or notice of proposed insurance within 10 days of incurring the indebtedness and to receive a refund of any premium paid if the debtor is not satisfied with the insurance for any reason, as required by s. 424.203 (4), Stats., shall be given with the policy, certificate or notice of proposed insurance.

(j) Charges or premiums for credit life insurance or credit accident and sickness insurance may only be collected from debtors if the disclosure and authorization requirements of s. 422.202 (2s), Stats., are met. If 2 debtors are to be insured for credit life insurance each must receive the disclosure information and each one must request credit life insurance coverage. However, the individual policy or group certificate may be delivered to only one debtor.

(8) FILING OF POLICY FORMS. (a) All policy forms, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and riders to be delivered or issued for delivery in this state and the schedules of premium rates pertaining to them shall be filed with the commissioner. In the case of credit transactions covered under a group policy issued in another state or jurisdiction, the insurer shall file for approval only the group certificate, notice of proposed insurance and the premium rates to be used in this state.

(b) The commissioner shall, within 30 days after the filing of any policy, certificate of insurance, notice of proposed insurance, application for insurance, endorsement or rider, disapprove any form if the benefits provided in the form are not reasonable in relation to the premium charged, or if the form contains provisions which are unjust, unfair, inequitable, misleading, deceptive or which encourage misrepresentation of the coverage or are contrary to any law or administrative rule.

(c) If the commissioner notifies the insurer that the form is disapproved, the insurer shall not issue or use the form. The notice shall specify the reason for the disapproval and state that a hearing will be granted not less than 10 nor more than 30 days after a request in writing by the insurer.

(cm) No policy, certificate of insurance, notice of proposed insurance, nor any application, endorsement or rider, shall be issued or used until 30 days after it has been filed, unless the commissioner gives prior written approval.

(d) The commissioner may, at any time after a hearing held not less than 20 days after written notice to the insurer, withdraw approval of any form on any ground set forth in par. (b). The written notice of the hearing shall state the reason for the proposed withdrawal of approval. The insurer shall not issue or use any form after the effective date of the withdrawal of the approval.

(9) PREMIUMS AND REFUNDS. (a) Any insurer may revise its schedules of premium rates from time to time, and shall file such revised schedules with the commissioner. No insurer shall issue any credit life insurance policy or credit accident and sickness insurance policy if the premium rate exceeds that established by the filed rate schedules of the insurer.

(b) The amount charged to a debtor for any credit life or credit accident and sickness insurance shall not exceed the premiums charged by the insurer, as computed at the time the charge to the debtor is determined.

(c) If a creditor requires a debtor to make any payment for credit life insurance or credit accident and sickness insurance and an individual policy or group certificate of insurance is not issued, the creditor shall immediately give written notice to the debtor that coverage will not be issued and shall promptly make an appropriate credit to the account of the debtor.

(d) A creditor may not remit and an insurer may not collect on a monthly outstanding balance basis if the insurance charge or premium is included as part of the outstanding indebtedness. If the creditor adds identifiable insurance charges or premiums for credit insurance to the total amount of indebtedness and a direct or indirect finance, carrying, credit or service charge is made to the debtor in connection with the insurance charge, the creditor shall remit and the insurer shall collect on a single premium basis only.

(e) Dividends on participating individual policies of credit insurance shall be payable to the individual insureds. Payment of these dividends may be deferred until the policy is terminated.

(f) Each individual policy or group certificate shall provide that in the event of termination of the insurance prior to the scheduled maturity date of the indebtedness any refund of an amount paid by the debtor for insurance shall be paid or credited promptly to the person entitled to the refund. The policy certificate may prescribe a minimum refund of $1 and no refund of a lesser amount need be made. The sum of the refunds due on all credit life insurance or credit accident and sickness insurance being terminated in connection with the indebtedness and all other credits due to the customer under chs. 421 to 427, Stats., shall be used to determine if a refund is due.

(g) Schedules for computing refunds in the event of cancellation of credit life or credit accident and sickness insurance prior to the scheduled maturity date of coverage shall meet the following minimum requirements:

1. For the following coverages paid for on a single premium or single charge basis, the refund shall be equal to or greater than the unearned gross premium or charge amount computed by the "sum of the digits" methods, commonly referred to as the "Rule of 78":

a. Credit life insurance that decreases by a uniform amount each month until the amount becomes zero;

b. Credit life insurance providing coverage for the full term of an indebtedness that is repayable in substantially equal installments with coverage amounts that equal or approximate the actual or net scheduled amount necessary to liquidate the indebtedness; and

c. Credit accident and sickness insurance with substantially equal monthly benefit amounts and with insurance coverage and maximum benefit periods that are coterminous.

2. For credit life insurance or credit accident and sickness insurance paid for on a monthly outstanding balance basis, the refund shall be equal to or greater than the pro rata unearned gross premium or charge.

3. For all coverages not described in subds. 1. and 2., the refund shall be equal to or greater than that based on the actuarial method, which is the prepaid premium or charge for scheduled benefits subsequent to the actual date of coverage termination computed at the schedule of premium rates or charges applicable to the coverage when it was effected.

Note: Examples of these coverages include truncated credit life insurance and floating critical period credit disability insurance.

4. Refunds shall be based on the number of full months prepaid from the actual date of coverage termination to the scheduled

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maturity date of coverage, counting a fractional month of 16 days or more as a full month.

5. Upon termination of indebtedness repayable in a single sum prior to scheduled maturity date, the refund shall be computed from the date of termination to the maturity date. If less than 16 days of a loan month has been earned, no charge may be made for that loan month, but if 16 days or more has been earned, a full month may be charged.

(h) If an insured's indebtedness is transferred to another creditor, any group credit life insurance or group credit accident and sickness insurance issued on that indebtedness may be continued, but the creditor policyholder shall advise the insurer of each transfer within 30 days of its effective date.

(i) Voluntary prepayment of indebtedness. If a debtor prepays the indebtedness other than as a result of death or through a lump sum disability payment:

1. Any credit life insurance covering this indebtedness shall be terminated and an appropriate refund of the credit life insurance premium shall be paid to the debtor; and

2. Any credit accident and sickness insurance covering this indebtedness shall be terminated and an appropriate refund of the credit accident and sickness insurance premium shall be paid to the debtor. If a claim under such coverage is in progress at the time of prepayment, the amount of refund may be determined as if the prepayment did not occur until the payment of benefits terminates. No refund need be paid during any period of disability for which credit accident and sickness benefits are payable. A refund shall be computed as if prepayment occurred at the end of the disability period.

(j) Involuntary prepayment of indebtedness. If an indebtedness is prepaid by the proceeds of a credit life insurance policy covering the debtor or by a lump sum payment of a disability claim under a credit insurance policy covering the debtor, then it shall be the responsibility of the insurer to see that the following are paid to the insured debtor, if living, or the beneficiary, other than the creditor named by the debtor, or to the debtor's estate:

1. In the case of prepayment by the proceeds of a credit life insurance policy, or by the proceeds of a lump sum total and permanent disability benefit under credit life coverage, an appropriate refund of the credit accident and sickness insurance premium;

2. In the case of prepayment by a lump sum disability payment under credit accident and sickness coverage, an appropriate refund of the credit life insurance premium;

3. In either case, the amount of the benefits in excess of the amount required to repay the indebtedness after crediting any unearned interest or finance charges.

(10) CLAIMS AND EXAMINATION PROCEDURES. (a) All claims shall be reported to the insurer or its designated claim representative promptly, and the insurer shall maintain adequate claim files. All claims shall be settled as soon as possible and in accordance with the terms of the insurance contract.

(b) All claims shall be paid either by a draft drawn upon the insurer or by a check of the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or upon direction of such claimant to another specified person.

(c) No plan or arrangement shall be used in which any person, firm or corporation other than the insurer or its designated claim representative shall be authorized to settle or adjust claims. The creditor shall not be designated as claim representative for the insurer in adjusting claims but a group policyholder may, by arrangement with the group insurer, draw drafts or checks in payment of claims due to the group policyholder subject to audit and review by the insurer. This paragraph shall not be construed to relieve the insurer of the responsibility for proper settlement, adjustment and payment of all claims in accordance with the terms of the insurance contract and this section.

(d) The insurer shall make a good faith examination of each credit life and credit accident and sickness insurance account in the first year of the account and annually thereafter. The examination shall be made to assure that the creditor is conducting the insurance program in compliance with the policy provisions, the insurer's administrative instructions furnished the creditor to implement the insurance program, and with the applicable credit insurance law and regulation of Wisconsin. The examination must include verification of the accuracy of the computation of premium payments, insurance charges made to debtors, and claim payments reported to the insurer by the creditor. The insurer shall maintain records of examinations for 2 years.

(11) CHOICE OF INSURER. When credit life insurance or credit accident or sickness insurance is required as additional security for any indebtedness, the debtor shall, upon request to the creditor, have the option of furnishing the required amount of insurance through existing policies of insurance owned or controlled by the debtor or of procuring and furnishing the required coverage through any insurer authorized to transact insurance business within this state.

(12) CREDIT INSURANCE PREMIUM RATE FILINGS. (a) Every credit insurer shall file with the commissioner every maximum premium rate schedule applicable to credit life or credit accident and sickness insurance in this state at least 30 days before the proposed effective date.

(b) The benefits provided under a credit life or credit accident and sickness insurance form shall be presumed to be reasonable in relation to the premium rate charged if the premium rates filed do not exceed the prima facie premium rate standards set forth in subs. (14) and (15) and if the forms provide benefits which are no more restrictive than the coverage standards enumerated in subs. (14) and (15).

(c) Nothing in this subsection shall preclude an insurer from requesting approval of the commissioner for premium rates higher or lower than the prima facie rate standards on the basis of the credible mortality or morbidity actually experienced or reasonably anticipated.

(13) USE OF PRIMA FACIE PREMIUM RATES GENERALLY. (a) An insurer that files rates or has rates on file that are not in excess of the prima facie rates may use those rates without further proof of their reasonableness.

(b) The initial prima facie premium rates are as shown in subs. (14) and (15) for the plans and benefits described in these subsections and shall remain in effect through December 31, 1990.

(bm) 1. The initial basic loss ratio for credit life insurance, as shown in par. (d), shall remain in effect through December 31, 1995. Effective January 1, 1996, the commissioner shall adopt a basic loss ratio for credit life insurance that reflects a specific allowance for expenses. The expense factor adopted effective January 1, 1996, shall remain effective for a period of ten (10) years. At the end of ten (10) years the factor will be reviewed for possible adjustment.

2. This new loss ratio and the resultant new prima facie credit life premium rates shall remain effective until December 31, 1999. Effective January 1, 2000, the credit life premium rates shall be subject to adjustment every three years as outlined in par. (c). These periodic adjustments of the credit life premium rates shall only be based on differences in claim costs. Any new basic loss ratio resulting from a change in claim costs will be provided with the written notice of the prima facie premium rates to be used for the next three−year period.

(c) On or before October 1, 1990, and each 3 years after that, except that the initial prima facie credit life rates adopted under par. (bm) shall remain effective until December 31, 1999, the commissioner shall give written notice to all authorized insurers specifying the prima facie premium rates to be effective for the three−year period beginning on the next January 1. Such rates

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shall be determined based on experience data submitted by all insurers pursuant to sub. (19) for the immediately preceding 3 calendar years and shall be calculated as follows:

1. For each category of coverage specified in par. (d) or (e), total prima facie earned premium and total incurred claims shall be calculated for each year for all insurers.

2. If, for any category of coverage, the prima facie premium rate in effect at any time during the three−year period differs from that in effect at the end of of the three−year period, prima facie premiums for that category of coverage shall be adjusted to reflect what the prima facie premium would have been if the prima facie premium rate in effect at the end of the three−year period had been in effect throughout the full three−year period;

3. For each category of coverage, the resulting data are summed separately for the total 3 years for prima facie earned premium and for incurred claims;

4. The credit life insurance adjustment factor is determined as follows:

a. Total credit life insurance data are computed by summing the data for single life coverage and joint life coverage separately for prima facie earned premium and for incurred claims;

b. Total credit life insurance incurred claims are divided by total credit life insurance prima facie earned premiums to determine the credit life insurance loss ratio at prima facie rates, rounded to 3 decimal places; and

c. Prior to January 1, 1996, the credit life insurance loss ratio at prima facie rates is divided by the basic loss ratio for credit life insurance. The quotient, rounded to 2 decimal places, is the credit life insurance adjustment factor; and

d. Effective January 1, 1996, and thereafter, the single premium uniformly decreasing single life credit life insurance prima facie rate is the quotient of the following formula rounded to 2 decimal places:

$$\text{Prima Facie Rate} = \frac{\text{Claim Costs} + .196}{.92}$$

where Claim Costs are calculated by dividing total credit life insurance incurred claims by total credit life insurance prima facie earned premiums and multiplying the result by the current prima facie rate, rounded to 3 decimal places, and the other factors in the formula remain fixed until changed as outlined in par. (bm).

5. The credit accident and sickness insurance adjustment factor is determined using the same procedure specified in subd. 4., except that:

a. Data for the specifically described categories of credit accident and sickness insurance are summed separately for prima facie earned premium and for incurred claims;

b. A composite credit accident and sickness insurance basic loss ratio is computed as the average of the basic loss ratio for each category of coverage weighted by the corresponding proportionate amount of prima facie earned premium for that category of coverage; and

c. If the quotient of the credit accident and sickness loss ratio at prima facie rates divided by the composite credit accident and sickness basic loss ratio is greater than .95 and less than 1.05, the credit accident and sickness adjustment factor shall be 1.00.

6. Prior to January 1, 1996, for single premium uniformly decreasing single life credit life insurance coverage, the new prima facie premium rate per $100 of initial indebtedness per year equals the prima facie premium rate then in effect multiplied by the credit life insurance adjustment factor, rounded to the nearest cent. Effective January 1, 1996, this rate will be the rate calculated under subd. 4. d. This new prima facie premium rate is then multiplied by the following factors to derive the new prima facie premium rate for the indicated plan:

a. 1.85 for the single premium rate per $100 per year for level coverage on a single life, rounded to the nearest cent; or

b. 1.54 for the monthly premium rate per $1,000 outstanding balance coverage, rounded to the nearest one−tenth cent.

7. For credit accident and sickness coverage, the new prima facie premium rate per $100 initial coverage for each category of coverage and for each duration equals the then currently effective prima facie premium rate per $100 for the same category of coverage and duration multiplied by the credit accident and sickness insurance adjustment factor, rounded to the nearest cent.

(d) The initial basic loss ratio for credit life insurance shall be .50. The basic loss ratio for credit accident and sickness insurance shall vary by plan as follows:

1. 14 days retroactive waiting period—.60
2. 14 days nonretroactive elimination period—.59
3. 30 days retroactive waiting period—.57
4. 30 days nonretroactive elimination period—.52

(e) If a form provides for plans or benefits that differ from those described in subs. (14) and (15), the insurer shall demonstrate to the satisfaction of the commissioner that the premium rate or schedule of premium rates applicable to the form will or may reasonably be expected to achieve the applicable basic loss ratio or such other loss ratio as may be determined by the commissioner to be consistent with s. 424.209, Stats., or that the rate or rates are actuarially consistent with the prima facie premium rates.

(14) PRIMA FACIE CREDIT LIFE INSURANCE PREMIUM RATES. (a) If premiums are payable monthly on the outstanding insured balance basis for term insurance on a single insured debtor, the initial prima facie premium rate shall be $0.616 per month per $1,000 of outstanding insured indebtedness.

(b) If premiums are payable on a single premium basis for straight−line decreasing term insurance on a single insured debtor, the initial prima facie premium rate shall be $0.40 per annum per $100 of initial insured indebtedness.

(c) If premiums are payable on a single premium basis for level term insurance on a single insured debtor, the initial prima facie premium rate shall be $0.74 per annum per $100 of initial insured indebtedness.

(d) The prima facie premium rate for credit life insurance providing coverage on 2 lives with respect to a single indebtedness shall be 150% of the corresponding single life prima facie premium rate until December 31, 1990, and shall be 167% of the corresponding single life prima facie premium rate on and after January 1, 1991.

(e) The prima facie rates shall apply to all policies providing credit life insurance which are offered to all debtors.

1. For initial amounts of credit life insurance in excess of $15,000, if evidence of individual insurability is not required, the policy shall contain no exclusion for pre−existing conditions except for those conditions which manifested themselves to the insured debtor by requiring medical advice, diagnosis, consultation or treatment, or would have caused a reasonably prudent person to have sought medical advice, diagnosis, consultation or treatment, within 6 months preceding the effective date of coverage and which causes loss within 6 months following the effective date of coverage. Under open−end credit plans, the effective date of coverage applies separately with respect to each purchase or loan to which the coverage relates.

2. Whether or not evidence of insurability is required the policy shall contain:

a. No suicide exclusions other than suicide within one year of the effective date of coverage. Under open−end credit plans, the effective date of coverage applies separately with respect to each purchase or loan to which the coverage relates;

b. Either no age restrictions, or age restrictions making ineligible for coverage debtors not less than age 65 or over at the time the indebtedness is incurred, or debtors who will have attained at least age 66 on the maturity date of the indebtedness. Insurance written in connection with an open−end credit plan may exclude

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from the classes eligible for insurance, classes of debtors determined by age, and may provide for the cessation of the insurance or a reduction in the amount of insurance upon attainment of not less than age 65.

c. At the option of the insurer and in lieu of a pre−existing condition exclusion, for monthly outstanding balance premium coverage on open−end credit transactions, a provision limiting the amount of insurance payable on death due to natural causes to the balance of the loan as it existed 6 months prior to the date of death if there have been one or more increases in the outstanding insured balance of the loan during such 6 months period and if evidence of individual insurability is not required at the time of the increase in the amount of insurance.

3. Credit life insurance provided on debts where the initial amount of credit life insurance would be $15,000, or less, shall be provided on a guaranteed issue basis, provided that the debtor is not ineligible for coverage due to age. The insurer may also use the preexisting conditions and suicide exclusions appearing in subds. 1. and 2. a., respectively.

(f) Evidence of insurability may be based either on questions relating to specific health history or based on an objective test such as active full−time work.

(15) PRIMA FACIE CREDIT ACCIDENT AND SICKNESS PREMIUM RATES. (a) The initial credit accident and sickness prima facie premium rates for the insured portion of an indebtedness repayable in equal monthly installments, where the insured portion of the indebtedness decreases uniformly by the amount of the monthly installment paid, shall be as set forth in subds. 1. and 2.

1. As set forth in Appendix A, if premiums are payable on a single premium basis for the duration of the coverage; or

2. If premiums are paid on the basis of a premium rate per month per $1,000 of outstanding insured indebtedness, these premiums shall be computed according to a formula approved by the commissioner as producing a rate or rates actuarially consistent with the single premium prima facie premium rates.

(b) The prima facie rates shall apply to policies providing credit accident and sickness insurance which are issued with or without evidence of insurability, and which are offered to all debtors.

1. If evidence of individual insurability is not required there shall be no exclusion for pre−existing conditions, except for those conditions which manifested themselves to the insured debtor by requiring medical advice, diagnosis, consultation or treatment, or would have caused a reasonably prudent person to have sought medical advice, diagnosis, consultation or treatment, within 6 months preceding the effective date of coverage and which causes loss within 6 months following the effective date of coverage. Under open−end credit plans, the effective date of coverage applies separately with respect to each purchase or loan to which the coverage relates;

2. Whether or not evidence of insurability is required the policy shall contain:

a. No provision which excludes or restricts liability in the event of disability caused in a certain specified manner except that the policies may contain provisions excluding or restricting coverage in the event of normal pregnancy, intentionally self−inflicted injuries, flight in nonscheduled aircraft, war, military service or foreign travel or residence.

b. Either no age restrictions, or age restrictions making ineligible for coverage debtors not less than age 65 or over at the time the indebtedness is incurred, or debtors who will have attained at least age 66 on the maturity date of the indebtedness. Insurance written in connection with an open−end credit plan may exclude from the classes eligible for insurance classes of debtors determined by age, and may provide for the cessation of the insurance or a reduction in the amount of insurance upon attainment of not less than age 65.

c. A provision which defines disability as the inability to perform any occupation for which the debtor is reasonably fitted by education, training or experience after the period of disability has lasted for 12 consecutive months. During the first 12 consecutive months of disability, the definition must relate the disability to the occupation of the debtor at the time the disability occurred.

(c) No individual or group policy of credit accident and sickness insurance shall be delivered or issued for delivery if the benefits are payable after a waiting period of less than 14 days regardless of whether the payment of benefits is retroactive to the first day of disability.

(16) USE OF RATES HIGHER THAN PRIMA FACIE RATES. (a) An insurer may file for approval and use rates that are higher than the prima facie rates if it can be reasonably expected that the use of these higher rates will result in a ratio of claims incurred to premiums earned that is not less than the applicable basic loss ratio.

(b) These higher rates may be:

1. Applied uniformly to all applicable credit insurance of the insurer; or

2. Applied according to a case−rating procedure on file with and approved by the commissioner.

(c) An insurer electing to file a case rating procedure may either file its own plan for approval by the commissioner or may use the standard case rating procedure specified in sub. (17).

(17) STANDARD CASE RATING PROCEDURE. (a) An insurer, by written notice to the commissioner of its election to do so, may file and use rates determined by the standard case rating procedure. If elected, the procedure shall be used by the insurer to rate all of its credit insurance in this state.

(b) The case rate shall be the prima facie premium rate if the life years exposure is less than the minimum life years exposure shown below:

Plan of Benefits	Minimum Life Years Exposure
Life—Single	1,900
Life—Joint	1,200
Accident and Sickness:	
14 Day Non Retroactive	100
14 Day Retroactive	100
30 Day Non Retroactive	200
30 Day Retroactive	200

(c) If the life years exposure is not less than the minimum life years exposure, the case rate for a plan of benefits shall be calculated as the product of the deviation factor determined in par. (d) and the prima facie premium rate in effect at the end of the experience period. The case rates shall be rounded to the nearest cent per $1000 indebtedness for single premiums payable on the basis of monthly outstanding balances.

(d) Deviation factor determination. The deviation factor shall be determined using the following worksheet:

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Plan of Benefits	Prima Facie Incidence	Initial Basic Loss Ratio
Life—Single	0.00369	.50
Life—Joint	0.00554	.50
Accident and Sickness:		
14 Day Non Retroactive	0.05200	.59
14 Day Retroactive	0.05980	.60
30 Day Non Retroactive	0.03081	.52
30 Day Retroactive	0.03543	.57
Basic Data Entry:		
Plan of Coverage		_____
Actual Earned Premium		_____
Prima Facie Earned Premium		_____
Incurred Claims		_____
Number of Years in Experience Period		_____
Life Years Exposure		_____

All calculations below shall be taken to five decimal places:

Line Number	Description of Item	Value
1	Prima Facie Incidence	_____
2	Life Years Exposure	_____
3	Prima Facie Loss Ratio	_____
4	Basic Loss Ratio	_____
5	Line 3 Divided by Line 4	_____
6	Line 5 Times Line 1	_____
7	Line 6 Minus Line 1	_____
8	Line 2 Times Line 7	_____
9	Line 8 Times Line 7	_____
10	One Minus Line 1	_____
11	Line 10 Times Line 1	_____
12	Line 9 Minus Line 11	_____

IF LINE 12 IS GREATER THAN ZERO, GO ON TO LINE 13. IF LINE 12 IS LESS THAN OR EQUAL TO ZERO, THE DEVIATION FACTOR IS ONE AND THE CASE RATE IS THE PRIMA FACIE RATE BASIS CURRENTLY IN EFFECT.

13	Line 2 Times Line 6	_____
14	One Plus Two Times Line 13	_____
15	One Plus Line 2	_____
16	Line 13 Times Line 6	_____
17	Line 14 Squared	_____
18	Line 15 Times Line 16 Times Four	_____
19	Line 17 Minus Line 18	_____
20	Square Root of Line 19	_____
21	Two Times Line 15	_____
22	Line 14 Divided by Line 21	_____
23	Line 20 Divided by Line 21	_____
24	Line 22 Plus Line 23	_____
25	Line 22 Minus Line 23	_____

IF LINE 12 IS LESS THAN OR EQUAL TO ZERO, LINE 26 EQUALS LINE 1; OTHERWISE, IF LINE 5 EXCEEDS ONE, LINE 26 EQUALS LINE 25, AND IF LINE 5 IS LESS THAN ONE, THEN LINE 26 EQUALS LINE 24

26	Credibility Adjusted Incidence	_____
27	Deviation Factor	_____

The greater of 1 or Line 26 divided by Line 1

(e) The period of time for which a case rate may be used by an insurer may not exceed the length of the experience period on which the rate is based. However, the period may not be less than one year nor more than 3 years.

(18) CHANGE OF INSURERS. (a) If a creditor changes insurers, the case rate applicable to that creditor's coverage may be used by the replacing insurer under the same terms and conditions that apply to the replaced insurer;

(b) If the case rate is higher than the prima facie premium rate on the date of change, the replacing insurer shall furnish notice of the change of insurers to the commissioner within 30 days following the date of change. The notice shall include the identity of the creditor and of the replaced insurer, the approved case rate applicable to the creditor's coverage and the rate to be charged by the replacing insurer, and shall request that the commissioner inform the replacing insurer of the termination date of the case rate applicable to the creditor's coverage. In no event shall the replacing insurer charge a rate higher than that approved for use by the replaced insurer for the remainder of the case rate period or, if sooner, until a new case rate for that creditor's coverage is approved by the commissioner.

(19) FILING OF EXPERIENCE INFORMATION. Every insurer having credit life insurance or credit accident and sickness insurance in force in this state shall report Wisconsin experience data annually on the annual statement Credit Insurance Experience Exhibit form (available at no charge from the Commissioner.) The experience data for each calendar year shall be submitted as specified in the instructions to the annual statement and according to the requirements of sub. (20).

(20) FINANCIAL STATEMENT MINIMUM RESERVES. (a) Each insurer shall show, as a liability in any financial statement or report required under s. 601.42, Stats., except for the report required to be filed under sub. (19), its policy or unearned premium reserve in an amount not less than as computed in pars. (b) through (e). If a credit insurance policy provides any combination of life insurance benefits, disability benefits and accident and sickness insurance benefits, a reserve must be established separately for the life insurance benefits, for the disability benefits and for the accident and sickness insurance benefits.

(b) The minimum mortality and interest standards for active life reserves for individual credit life insurance policies shall be not less than 100% of the commissioners 1958 standard ordinary mortality table at 4½% annual interest.

(c) The minimum mortality and interest standards for active life reserves for group credit life insurance policies shall be not less than 100% of the commissioners 1960 standard group mortality table at 4½% annual interest.

(d) The minimum morbidity and interest standards for active life reserves for credit accident and sickness insurance policies and for disability benefits in credit life insurance policies shall be not less than the greater of 130% of the commissioners 1964 disability table at 4½% annual interest, or the unearned premium reserve.

(e) With the approval of the commissioner, a company may, for valuation purposes, use any appropriate mortality or morbidity table, in lieu of those specified in pars. (b), (c) and (d), that is based on credible credit life or disability experience and either explicitly or implicitly has adequate margins for the present value of all future unaccrued liabilities.

(f) Unearned premium reserves shall be computed as follows:

1. Unearned premiums shall be reported consistently as of the beginning and the end of each year, and shall be based on the premium that would be charged for the remaining amount and term of coverage using the premium rate or schedule of premium rates in effect at the time the coverage became effective. The following calculation bases shall be deemed to comply with this requirement in lieu of a precise calculation:

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a. For single premium uniformly decreasing credit life insurance coverage, the "sum of the digits" method, commonly known as the "Rule of 78";

b. For single premium credit accident and sickness coverage with substantially equal monthly benefits and with conterminous coverage and benefit periods, the arithmetic mean of the unearned premium calculated according to the "sum of the digits" method and the pro rata unearned premium calculated as the original premium multiplied by the ratio of the remaining coverage term to the original coverage term;

c. For premiums payable on a monthly outstanding balance basis, single premium level life coverage or any other coverage where the benefit amount remains constant throughout the remaining coverage period, the pro rata unearned premium calculated as the original premium multiplied by the ratio of the remaining coverage term to the original coverage term;

d. For decreasing credit life insurance coverage provided for the full term of the indebtedness where the benefit is equal to the actual or scheduled net amount necessary to liquidate the indebtedness, the unearned premium calculated as the original premiums multiplied by the ratio of the scheduled remaining dollar−months of coverage to the scheduled initial dollar−months of coverage. Dollar−months of coverage may be approximated using an assumed interest rate that is reasonably representative of the interest rates applicable to all indebtedness with respect to which coverage is provided on this basis;

e. For credit life insurance coverage providing a combination of level and decreasing benefits, or providing a truncated coverage period or providing full−term coverage of an indebtedness that requires a balloon payment, an appropriate combination of methods described in this paragraph; or

f. Any other reasonable approximation method approved by the commissioner.

g. In this paragraph, a "dollar−month of coverage" means one dollar of coverage for one month.

2. Unearned premium for partial months may be calculated on an exact daily basis, on a basis assuming that the valuation date occurs in the middle of each installment period or using the method commonly known as the "15 day 16 day rule" in which the value at the beginning of the month is used if less than 16 days have elapsed in the current month and the value at the end of the month is used if more than 15 days have elapsed in the current month. For the purpose of the "15 day−16 day rule," the current month shall be deemed to begin on the day following the most recent payment due date of the indebtedness and end on the next succeeding payment due date. The valuation date shall be counted as a full day.

3. Claim reserves and liabilities shall be reported on a consistent basis from year to year. Any change in the basis of calculation shall be disclosed, together with a recalculation of all items as of the end of the preceding calendar year according to the revised basis.

(22) PENALTY. Violations of this section shall subject the violator to ss. 601.64 and 601.65, Stats.

History: Cr. Register, August, 1972, No. 200, eff. 9−1−72; cr. (2) (c), (6) (h) and (8) (h); am. (4) (b), (5), (8) (f), (12), (13) (a), (14) (e), and r. (17) (a), Register, February, 1973, No. 206, eff. 3−1−73; am. (4), (5), (6) (a) 6., (6) (h), (8) (f), (12) (g) 2., (13) (c) 3., (14) (c) and (d) and cr. (6) (i) and (13) (c) 5., Register, April, 1975, No. 232, eff. 5−1−75; am. (13) (b), Register, June, 1975, No. 234, eff. 7−1−75; emerg. am. (1) and (2), eff. 6−22−76; am. (1) and (2), Register, September, 1976, No. 249, eff. 10−1−76; am. (4) and (11) (d), cr. (12) (h) and (13) (d), Register, March, 1977, No. 255, eff. 4−1−77; am. (1), (2) and (14) (c), Register, March, 1979, No. 279, eff. 4−1−79; am. (12) (b) to (e), Register, September, 1981, No. 309, eff. 10−1−81; r. (19) under s. 13.93 (2m) (b) 16., Stats., Register, December, 1984, No. 348; reprinted to correct printing errors in (13) (b), (14) (c) and (f), Register, June, 1986, No. 366; r. and recr. Register, November, 1987, No. 383, eff. 1−1−88; am. (8) (c) and (17) (d), Register, November, 1988, No. 395, eff. 12−1−88; r. and recr. (9) (g), am. (13) (b) and (c) (intro.), (14) (d), (19) (intro.), (20) (a) and Appendix B, r. (20) (d), renum. (20) (e) to (g) to be (20) (d) to (f) and am. (20) (e) and (f), Register, November, 1989, No. 407, eff. 12−1−89, except (9) (g) eff. 4−1−90; emerg. cr. (13) (bm), (c) 4. d., (e) 3., am. (13) (c) (intro.), 1., 4. c., 6. (intro.), (d) (intro.), (14) (e) 1., 2. b., (15) (b) 2. b., (17) (d) and (19) (intro.), r. (19) (a) and (b), (21), Appendix B, r. and recr. (20) (f), eff. 1−1−96; cr. (13) (bm), (c) 4. d., (e) 3., am. (13) (c) (intro.), 1., 4. c., 6. (intro.), (d) (intro.), (14) (e) 1., 2. b., (15) (b) 2. b., (17) (d) and (19) (intro.), r. (19) (a) and (b), (21), Appendix B, r. and recr. (20) (f), Register, March, 1996, No. 483, eff. 4−1−96.

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Ins 3.25 Appendix A

GROUP CREDIT DISABILITY INSURANCE SINGLE PREMIUM RATES
PER $100 OF INITIAL INSURED INDEBTEDNESS

BENEFITS PAYABLE AFTER:

Original number of equal monthly installments	The 14th day of disability Retroactive to first day	Non−retroactive	The 30th day of disability Retroactive to first day	Non−retroactive
6	1.74	1.39	1.10	.69
7	1.84	1.56	1.30	.80
8	1.94	1.66	1.40	.89
9	2.02	1.74	1.49	.97
10	2.10	1.82	1.58	1.05
11	2.17	1.89	1.63	1.12
12	2.23	1.95	1.68	1.18
13	2.29	2.01	1.72	1.24
14	2.35	2.07	1.75	1.30
15	2.41	2.13	1.79	1.35
16	2.46	2.18	1.82	1.40
17	2.51	2.23	1.86	1.45
18	2.56	2.27	1.89	1.50
19	2.60	2.32	1.91	1.54
20	2.65	2.36	1.94	1.59
21	2.69	2.40	1.97	1.62
22	2.73	2.44	1.99	1.64
23	2.77	2.48	2.02	1.67
24	2.81	2.52	2.04	1.69
25	2.85	2.56	2.06	1.71
26	2.88	2.60	2.09	1.73
27	2.92	2.63	2.11	1.75
28	2.95	2.67	2.13	1.77
29	2.99	2.70	2.15	1.79
30	3.02	2.74	2.17	1.82
31	3.06	2.77	2.19	1.83
32	3.09	2.80	2.21	1.85
33	3.12	2.83	2.23	1.87
34	3.15	2.86	2.25	1.89
35	3.18	2.90	2.27	1.91
36	3.21	2.93	2.29	1.93
37	3.24	2.96	2.30	1.94
38	3.27	2.99	2.32	1.96
39	3.30	3.01	2.34	1.98
40	3.33	3.04	2.35	1.99
41	3.36	3.07	2.37	2.01
42	3.39	3.10	2.39	2.03
43	3.41	3.13	2.40	2.04
44	3.44	3.15	2.42	2.06
45	3.47	3.18	2.44	2.08
46	3.50	3.21	2.45	2.09
47	3.52	3.23	2.47	2.11
48	3.55	3.26	2.48	2.12
49	3.57	3.29	2.50	2.14
50	3.60	3.31	2.51	2.15
51	3.62	3.34	2.53	2.16
52	3.65	3.36	2.54	2.18
53	3.67	3.39	2.56	2.19
54	3.70	3.41	2.57	2.21
55	3.72	3.43	2.58	2.22
56	3.75	3.46	2.60	2.24

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BENEFITS PAYABLE AFTER:

Original number of equal monthly installments	The 14th day of disability Retroactive to first day	Non−retroactive	The 30th day of disability Retroactive to first day	Non−retroactive
57	3.77	3.48	2.61	2.25
58	3.79	3.51	2.63	2.26
59	3.82	3.53	2.64	2.28
60	3.84	3.55	2.65	2.29
61	3.88	3.58	2.68	2.30
62	3.91	3.60	2.69	2.32
63	3.93	3.62	2.70	2.33
64	3.95	3.64	2.72	2.34
65	3.97	3.67	2.73	2.35
66	4.00	3.69	2.74	2.37
67	4.02	3.71	2.76	2.38
68	4.04	3.73	2.77	2.39
69	4.06	3.75	2.78	2.40
70	4.08	3.77	2.79	2.42
71	4.11	3.80	2.81	2.43
72	4.13	3.82	2.82	2.44
73	4.15	3.84	2.83	2.45
74	4.17	3.86	2.84	2.47
75	4.19	3.88	2.85	2.48
76	4.21	3.90	2.87	2.49
77	4.23	3.92	2.88	2.50
78	4.25	3.94	2.89	2.51
79	4.27	3.96	2.90	2.52
80	4.29	3.98	2.91	2.54
81	4.31	4.00	2.92	2.55
82	4.33	4.02	2.94	2.56
83	4.35	4.04	2.95	2.57
84	4.37	4.06	2.96	2.58
85	4.39	4.08	2.97	2.59
86	4.41	4.10	2.98	2.60
87	4.43	4.12	2.99	2.61
88	4.45	4.14	3.00	2.63
89	4.47	4.16	3.01	2.64
90	4.49	4.18	3.03	2.65
91	4.51	4.20	3.04	2.66
92	4.52	4.21	3.05	2.67
93	4.54	4.23	3.06	2.68
94	4.56	4.25	3.07	2.69
95	4.58	4.27	3.08	2.70
96	4.60	4.29	3.09	2.71
97	4.62	4.31	3.10	2.72
98	4.64	4.32	3.11	2.73
99	4.65	4.34	3.12	2.74
100	4.67	4.36	3.13	2.75
101	4.69	4.38	3.14	2.76
102	4.71	4.40	3.15	2.77
103	4.73	4.41	3.16	2.78
104	4.74	4.43	3.17	2.79
105	4.76	4.45	3.18	2.80
106	4.78	4.47	3.19	2.81
107	4.80	4.49	3.20	2.82
108	4.81	4.50	3.21	2.84
109	4.83	4.52	3.22	2.84
110	4.85	4.54	3.23	2.85

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BENEFITS PAYABLE AFTER:

Original number of equal monthly installments	The 14th day of disability Retroactive to first day	Non−retroactive	The 30th day of disability Retroactive to first day	Non−retroactive
111	4.86	4.55	3.24	2.86
112	4.88	4.57	3.25	2.87
113	4.90	4.59	3.26	2.88
114	4.92	4.61	3.27	2.89
115	4.93	4.62	3.28	2.90
116	4.95	4.64	3.29	2.91
117	4.97	4.66	3.30	2.92
118	4.98	4.67	3.31	2.93
119	5.00	4.69	3.32	2.94
120	5.02	4.71	3.33	2.95

Formula 1.25 x Claim Cost + $.60 (subject to a maximum of 2 x Claim Cost)

Ins 3.26 Unfair trade practices in credit life insurance and credit accident and sickness insurance. (1) PURPOSE. The purpose of this rule is to assist in the maintenance of a fair and equitable credit life insurance and credit accident and sickness insurance market. This rule interprets, including but not limited to, the following ss. 601.04, 601.01 (1), (2), (3), (7) and (8), 601.41 (1), (2) and (3), Stats., and ch. 628, Stats.

(2) SCOPE. This rule shall apply to the transaction of credit life insurance as defined in s. Ins 6.75 (1) (a) 1. and s. 632.44 (3), Stats., and the transaction of credit accident and sickness insurance as defined in s. Ins 6.75 (1) (c) 1. or (2) (c) 1.

(3) UNFAIR TRADE PRACTICES DEFINED. The following acts, whether done directly or indirectly, in consideration of or in connection with a policy issued or proposed to be issued are defined to be prohibited unfair trade practices in the transaction of insurance described in sub. (2):

(a) The offer or grant by an insurer of any special favor or advantage, or any valuable consideration or inducement not set out in the insurance contract. The payment of agents' commissions, reported annually in Schedule 24S, shall not be a violation of this paragraph but the acts cited in pars. (b), (c), (d), (e) and (f) may not in any way be construed as agents' commissions.

(b) The offer to deposit or the deposit with a bank or other financial institution, money or securities of the insurer or of any affiliate of the insurer with the design or intent that the deposit offset or take the place of a deposit of money or securities which otherwise would be required of the creditor by such bank or financial institution as a compensating balance or offsetting deposit for a loan or other advancement.

(c) The deposit with a bank or other financial institution of money or securities without interest or at a lessor rate of interest than is currently being paid other depositors on similar deposits with such bank or other financial institution. This shall not be construed to prohibit the maintenance by an insurer of such demand deposits as are reasonably necessary for use in the ordinary course of business of the insurer.

(d) The offer to sell or the sale of any capital stock or other security or certificate of indebtedness of the insurer or affiliated person.

(e) The offer to pay or the payment of any part of the premium for any insurance on the life, health or property of any creditor or any employee or other person affiliated with the creditor.

(f) The extension to the creditor of credit for the remittance of premium beyond the grace period of a group policy or for more than 45 days from the effective date of an individual policy.

(4) PENALTY. Violations of this rule shall subject the insurer or agent to s. 601.64, Stats.

History: Cr. Register, October, 1972, No. 202, eff. 11−1−72; emerg. am. (1) and (2), eff. 6−22−76; am. (1) and (2), Register, September, 1976, No. 249, eff. 10−1−76; am. (1) and (2), Register, March, 1979, No. 279, eff. 4−1−79; correction in (1) made under s. 13.93 (2m) (b) 7., Stats., Register, April, 1992, No. 436.

Ins 3.27 Advertisements of and deceptive practices in accident and sickness insurance. (1) PURPOSE. The interest of prospective purchasers of accident and sickness insurance must be safeguarded by providing such persons with clear and unambiguous statements, explanations, advertisements and written proposals concerning the policies offered to them. This purpose can best be achieved by the establishment of and adherence to certain minimum standards of and guidelines for conduct in the advertising and sale of such insurance which prevent unfair competition among insurers and are conducive to the accurate presentation and description to the insurance buying public of policies of such insurance. This rule interprets and implements, including but not limited to, the following Wisconsin Statutes: ss. 628.34 and 601.01 (3), Stats.

(2) SCOPE. This rule shall apply to any solicitation, representation or advertisement in this state of any insurance specified in s. Ins 6.75 (1) (c) or (2) (c), made directly or indirectly by or on behalf of any insurer, fraternal benefit society, nonprofit service plan subject to ch. 613, Stats., voluntary nonprofit sickness care plan organized under s. 185.981, Stats., interscholastic benefit plan organized under s. 616.08, Stats., or agent as defined in ch. 628, Stats.

(3) INTERPRETATION OF REQUIREMENTS APPLICABLE TO ADVERTISEMENTS. (a) The proper promotion, sale and expansion of accident and sickness insurance are in the public interest. This rule is to be construed in a manner which does not unduly restrict, inhibit or retard such promotion, sale and expansion.

(b) In applying this rule, it shall be recognized that advertising is essential in promoting a broader distribution of accident and sickness insurance. Advertising necessarily seeks to serve this purpose in various ways. Some advertisements are the direct or principal sales inducement and are designed to invite offers to contract. In other advertisements the function is to describe coverage broadly for the purpose of inviting inquiry for further information. Other advertisements are for the purpose of summarizing or explaining coverage after the sale has been made. Still other advertisements are solely for the purpose of promoting the interest of the reader in the concept of accident and sickness insurance or of promoting the insurer sponsoring the advertisement. These differences shall be considered in interpreting this rule.

(c) When applying this rule to a specific advertisement, the type of policy to which the advertisement refers and the detail, character, purpose, use and entire content of the advertisement shall be taken into consideration.

(d) This rule applies to individual, franchise, group and blanket accident and sickness insurance. Because these types of coverage differ in some respects, one interpretation will not always suffice; a specific interpretation for individual, franchise, group or blanket coverage may be indicated.

(e) The extent to which policy provisions need be disclosed in an advertisement will depend on the content, detail, character,

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purpose and use of the advertisement and the nature of the exceptions, reductions, limitations and other qualifications involved. The principal criterion is whether the advertisement has the capacity and tendency to mislead or deceive if such a provision is not disclosed.

(f) Whether an advertisement has the capacity and tendency to mislead or deceive shall be determined by the commissioner from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence within the segment of the public to which it is directed.

(4) COVERAGE TYPES. (a) An advertisement which is an invitation to apply shall clearly and prominently designate and at least briefly describe the type or types of coverage provided by the policy advertised. The level and extent of benefits provided by or available under the coverage shall also be clearly indicated.

(b) The following are the standard types of coverage designations and the minimum adequate form of description that must be used. Any type of coverage authorized by Wisconsin Statutes which is not reasonably included within one or more of the standard coverage types listed shall be similarly and appropriately named and described so as to clearly disclose the benefits provided.

1. 'Basic hospital expense benefits.' This coverage provides benefits for hospital room and board and miscellaneous hospital charges, based upon actual expenses incurred, up to stated maximum amounts.

2. 'Basic medical expense benefits.' This coverage provides benefits for medical benefits based upon actual expenses incurred, up to stated maximum amounts.

3. 'Basic surgical expense benefits.' This coverage provides benefits for surgical benefits based upon actual expenses incurred up to stated maximum amounts.

4. 'Major medical or comprehensive expense benefits.' These coverages provide high maximum benefit amounts covering almost all types of medical care and contain deductible and co−insurance features.

5. 'Disability income benefits.' This coverage provides periodic benefit payments to help replace income when the insured is unable to work as a result of illness or injury.

6. 'Hospital confinement indemnity benefits.' This coverage provides benefits in a stated amount for confinement in a hospital, regardless of the hospital expenses actually incurred by the insured, due to such confinement.

7. 'Accident only benefits.' This coverage provides benefits for losses for accidental bodily injury.

8. 'Specified disease or treatment benefits.' This coverage provides benefits for treatment of a specific disease or diseases named in the policy or for specified treatment.

(5) GENERAL DEFINITIONS. (a) An *advertisement* relating to accident and sickness insurance for the purpose of this rule includes the following:

1. Printed and published material, audio visual material and descriptive literature of an insurer used in newspapers, magazines, other periodicals, radio and TV scripts, the internet, web pages, electronic or computer presentations, billboards and similar displays, excluding advertisements prepared for the sole purpose of obtaining employees, agents or agencies.

2. Descriptive literature and sales aids of all kinds issued by an insurer or agent for presentation to members of the public, including but not limited to circulars, leaflets, booklets, depictions, illustrations and form letters.

a. Including material used in the solicitation of renewals and reinstatements except for communications or notices which mention the cost of the insurance but do not describe benefits,

b. Excluding material in house organs of insurers, communications within an insurer's own organization not intended for dissemination to the public, individual communications of a personal nature, and correspondence between a prospective group or blanket policyholder and an insurer in the course of negotiating a group or blanket policy,

c. Including group and blanket booklets, summaries of coverage and other explanatory material issued to insured persons, and

d. Excluding general announcements from group or blanket policyholders to eligible individuals that a contract has been written.

3. Prepared sales talks, presentations of material for use by agents and representations made by agents in accordance therewith, excluding materials to be used solely by an insurer for the training and education of its employees or agents, and

4. Envelopes used in connection with the above.

(b) A *policy* for the purpose of this rule includes any policy, plan, certificate, contract, agreement, statement of coverage, rider or endorsement which provides accident or sickness benefits whether on a cash indemnity, reimbursement or service basis,

1. Except such benefits contained in a policy providing another kind of insurance other than life, and

2. Except disability and double indemnity benefits included in life insurance, endowment or annuity contracts or contracts supplemental thereto which contain only such provisions relating to accident and sickness insurance as

a. Provide additional benefits in case of death or dismemberment or loss of sight by accident or

b. Operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity if the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract.

(c) An *insurer* for the purpose of this rule includes any person, individual, corporation, association, partnership, reciprocal exchange, inter−insurer, Lloyds, fraternal benefit society, nonprofit service plan subject to ch. 613, Stats., voluntary nonprofit sickness care plan organized under s. 185.981, Stats., interscholastic benefit plan organized under s. 616.08, Stats., and any other legal entity engaged in advertising a policy as herein defined.

(d) An *exception* for the purpose of this rule means any provision in a policy whereby coverage for a specified hazard is entirely eliminated. It is a statement of a risk not assumed under the policy.

(e) A *reduction* for the purpose of this rule means any provision in a policy which reduces the amount of the benefits. A risk of loss is assumed but payment upon the occurrence of such loss is limited to some amount or period less than would be otherwise payable had such reduction clause not been used.

(f) A *limitation* for the purpose of this rule means any provision in a policy which restricts coverage under the policy other than an exception or a reduction.

(g) An *invitation to apply* means an advertisement which is the direct or principal sales inducement and is designed to invite an offer to contract. Such an advertisement, which usually describes benefits in considerable detail, attempts to persuade the reader or listener to make application for the policy advertised. Such an advertisement would indicate what coverage the purchaser would receive and what such coverage would cost.

(h) An *invitation to inquire* means an advertisement which is designed to attract the reader's or listener's interest in the policy so that he or she will inquire for further information or details. Such an advertisement describes the policy broadly and withholds some information regarding the policy without which the reader or listener would not reasonably decide to apply for the policy.

(i) An *institutional advertisement* means one which is prepared solely to promote the reader's or listener's interest in the concept of accident and sickness insurance or of promoting the insurer sponsoring the advertisement.

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(j) A *testimonial* means any statement made by a policyholder, certificate holder or other person covered by the insurer which promotes the insurer and its policy by describing such person's benefits, favorable treatment or other experience under the policy.

(k) An *endorsement* for the purposes of sub. (13) means any statement promoting the insurer and its policy made by an individual, group of individuals, society, association or other organization which makes no reference to the endorser's experience under the policy.

(L) An *outline of coverage* means an appropriately and prominently captioned portion of a printed advertisement which is clearly set off from the rest of the advertisement by means such as placing it within a prominent border or box or printing it in contrasting color, or a separate appropriately captioned or titled printed statement, which advertisement portion or printed statement contains only a summary of the benefits provided, a designation of the applicable type or types of coverage as defined in sub. (4) and, under appropriate captions, the information required by subs. (10) and (11).

(m) An individual policy issued on a *group basis* means an individual policy or contract issued where:

1. Coverage is provided to employees or members or classes thereof defined in terms of conditions pertaining to employment or membership in an association or other group which is eligible for franchise or group insurance as provided in s. 600.03 (22) and (23), Stats.,

2. The coverage is not available to the general public and can be obtained and maintained only because of the covered person's membership in or connection with the group,

3. Premiums or subscription charges are paid to the insurer by the employer, association or some designated person acting on behalf of the employer, association or covered persons, and

4. The insurance plan is sponsored by the employer or association.

(6) ADVERTISEMENTS AND REPRESENTATIONS IN GENERAL. (a) Advertisements and representations shall be truthful and not misleading in fact or in implication and shall accurately describe the policy to which they apply. Words or phrases the meaning of which is clear only by implication or by familiarity with insurance terminology shall not be used.

(b) Oral representations shall conform to the requirements of this rule.

(7) SUITABILITY OF POLICIES. No agent or insurer shall recommend to a prospective buyer the purchase of any individual policy without reasonable grounds to believe that the recommendation is not unsuitable to the applicant. The agent or insurer shall make such inquiry as may be necessary under the circumstances to determine that the purchase of such insurance is not unsuitable for the prospective buyer. This requirement shall not apply to an individual policy issued on a group basis.

(8) OUTLINE OF COVERAGE. (a) Every advertisement of a specific individual policy or policies which constitutes an invitation to apply shall include an outline of coverage as defined in sub. (5) (L).

(b) Every agent at the time of taking an application for an individual policy shall furnish the applicant an outline of coverage as defined in sub. (5) (L).

(c) The requirement for an outline of coverage shall not apply to an advertisement or the taking of an application for an individual policy issued on a group basis or an individual conversion policy issued under a group or franchise insurance plan.

(9) DECEPTIVE WORDS, PHRASES OR ILLUSTRATIONS. (a) An advertisement shall not exaggerate a benefit or minimize cost by overstatement, understatement or incompleteness. Information shall not be omitted or words, phrases, statements, references or illustrations shall not be used if such omission or use has the capacity and tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. An advertisement referring to any policy benefit payable, loss covered or premium payable shall be sufficiently complete and clear as to avoid deception or the capacity and tendency to mislead or deceive.

(b) The words and phrases "all", "full", "complete","comprehensive", "unlimited", "up to", "as high as", "this policy will pay your hospital and surgical bills", "this policy will fill the gaps under Medicare and your present insurance" or "this policy will replace your income", or similar words and phrases shall not be used so as to exaggerate any benefit beyond the terms of the policy, but may be used only in such manner as fairly to describe such benefit.

(c) A policy covering only one disease or a list of specified diseases shall not be advertised so as to imply coverage beyond the terms of the policy. A particular disease shall not be referred to by more than one term so as to imply broader coverage than is the fact.

(d) The benefits of a policy which pays varying amounts for the same loss occurring under different conditions, or which pays benefits only when a loss occurs under certain conditions, shall not be advertised without disclosing the limited conditions under which the benefits referred to are provided by the policy.

(e) The maximum benefit available under a policy shall not be emphasized in a manner which exaggerates its relationship to any internal limits or other conditions of the policy.

(f) The aggregate amounts or the monthly or weekly benefits payable under coverages such as hospital or similar facility confinement indemnity or private duty nursing shall not be emphasized unless the actual amounts payable per day are disclosed with substantially equal prominence and in close conjunction with such statement. Any limit in the policy on the number of days of coverage provided shall be disclosed.

(g) Phrases such as "this policy pays $1800 for hospital room and board expenses" are incomplete without indicating the maximum daily benefit and the maximum time limit for hospital room and board expenses.

(h) An advertisement shall not state or imply that each member under a family policy is covered as to the maximum benefits advertised when such is not the fact.

(i) The importance of diseases rarely or never found in the class of persons to whom the policy is offered shall not be exaggerated in an advertisement.

(j) Examples of what benefits may be paid under a policy shall be shown only for losses from common illnesses or injuries rather than exceptional or rare illnesses or injuries.

(k) When a range of hospital room expense benefits is set forth in an advertisement, it shall be made clear that the insured will receive only the benefit indicated in the policy purchased. It shall not be implied that the insured may select his or her room expense benefit at the time of hospitalization.

(L) An advertisement shall not imply that the amount of benefits payable under a loss of time policy may be increased at time of disability according to the needs of the insured.

(m) The term "confining sickness" is an abbreviated expression and shall be explained if used in an advertisement.

(n) An advertisement shall not state that the insurer "pays hospital, surgical, medical bills", "pays dollars to offset the cost of medical care","safeguards your standard of living", "pays full coverage", "pays complete coverage", "pays for financial needs", "provides for replacement of your lost paycheck", "guarantees your paycheck", "guarantees your income","continues your income", "provides a guaranteed paycheck", "provides a guaranteed income" or "fills the gaps in Medicare" or use similar words or phrases unless the statement is literally true. Where appropri-

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ate, such or similar words or phrases may properly be used if preceded by the words"help", "aid", "assist" or similar words.

(o) An advertisement shall not state that the premiums will not be changed in the future unless such is the fact.

(p) An invitation to apply advertisement shall clearly indicate the provisions of any deductible under a policy.

(q) An advertisement shall not refer to a policy as a doctors policy or use words of similar import unless:

1. The advertisement includes a statement that the plan of benefits is not endorsed by or associated with any national, state or local medical society, or

2. The policy has been so endorsed by such a society and the advertisement meets the requirements of sub. (13).

(r) If a policy contains any of the following or similar provisions, an advertisement referring to such policy shall not state that benefits are payable in addition to other insurance unless the statement contains an appropriate reference to the coverage excepted:

1. An other insurance exception, reduction, limitation or deductible

2. A coordination of benefits or non−duplication provision

3. An other insurance in this company provision

4. An insurance in other insurers provision

5. A relation of earnings to insurance provision

6. A workers' compensation or employers' liability or occupational disease law exception, reduction, or limitation

7. A reduction based on social security benefits or other disability benefits, or

8. A Medicare exception, reduction, or limitation.

(s) An advertisement shall not state a policy's benefits are tax free unless an explanation of the rules applicable to the taxation of such types of accident and sickness benefits is clearly shown with equal prominence and in close conjunction with such statement. An advertisement of a benefit for which payment is conditioned upon confinement in a hospital or similar facility shall not state that such benefit is tax free.

(t) An advertisement shall not use the expressions "extra cash", "cash income", "income", "cash" or similar words or phrases in such a way as to imply that the insured will receive benefits in excess of the expenses incurred while being sick, injured or hospitalized.

(u) The description in advertisements of government insurance programs, including Medicare, and of changes in such program shall be accurate and not give an incorrect impression as to the need for supplementary coverage. If gaps in such programs are referred to, they shall be described fairly so that the reader or listener can determine how the policy being advertised covers such gaps.

(v) An invitation to apply advertisement which refers to a policy as being a Medicare supplement shall:

1. Contain a prominent statement indicating which Medicare benefits the policy is intended to supplement (for example, hospital benefits) and which Medicare benefits the policy will not supplement (for example, medical−surgical benefits) and shall clearly disclose any gaps in Medicare coverage for which the policy does not provide benefits and

2. Clearly indicate the extent of the benefits if the policy bases benefits on expenses incurred beyond what Medicare covers and thus provides somewhat limited benefits for short term hospital confinements.

(w) An advertisement may refer to immediate coverage or guaranteed issuance of a policy only if suitable administrative procedures exist so that the policy is issued within a reasonable time after the application is received.

(x) If an advertisement indicates an initial premium which differs from the renewal premium on the same mode, the renewal premium shall be disclosed with equal prominence and in close conjunction with any statement of the initial premium. Any increase in premium or reduction in coverage because of age shall be clearly disclosed.

(y) An advertisement shall not state that the policy contains no waiting period unless pre−existing conditions are covered immediately or unless the status of pre−existing conditions is disclosed with equal prominence and in close conjunction with such statement.

(z) An advertisement shall not state that no age limit applies to a policy unless applications from applicants of any age are considered in good faith and such statement clearly indicates the date or age to which the policy may be renewed or that the company may refuse renewal.

(za) An advertisement shall not state that no medical, doctor's or physical examination is required or that no health, medical or doctor's statements or questions are required or that such examination, statements or questions are waived or otherwise state or imply that the applicant's physical condition or medical history will not affect the policy unless:

1. The statement indicates with equal prominence that it applies only to the issuance of the policy or to both the issuance of the policy and the payment of claims, and

2. Pre−existing conditions are covered immediately under the policy or the period of time following the effective date of the policy during which pre−existing conditions are not covered is disclosed with equal prominence and in close conjunction with such statement.

(zb) An advertisement of a limited policy as defined in s. Ins 3.13 (2) (h) shall prominently indicate that the policy provided limited coverage with an appropriate statement such as "THIS IS A CANCER ONLY POLICY" or "THIS IS AN AUTOMOBILE ACCIDENT ONLY POLICY," and shall clearly disclose what injuries or sicknesses and what losses are covered.

(zc) An advertisement of a policy which provides benefits for injuries only or for sickness only shall prominently indicate that the policy covers injuries only or sickness only.

(zd) An advertisement shall not refer to a policy or coverage as being "special" unless it can be shown that there is a reasonable basis for the use of such a term.

(ze) An advertisement shall not set out exceptions, reductions or limitations from a policy worded in a positive manner to imply that they are beneficial features such as describing a waiting period as a benefit builder. Words and phrases used to disclose exceptions, reductions or limitations shall fairly and accurately describe their negative features. The words "only" or "minimum" or similar words or phrases shall not be used to refer to exceptions, reductions or limitations.

(zf) An advertisement shall not state or imply, or use similar words or phrases to the effect, that because no insurance agent will call and no commissions will be paid to agents the policy is a low cost plan.

(zg) Devices such as a safe drivers' award and other such awards shall not be used in connection with an advertisement.

(zh) An advertisement which describes or offers to provide information concerning the federal Medicare program or any related government program or changes in such programs shall:

1. Include no reference to such program on the envelope, the reply envelope or to the address side of the reply postal card, if any,

2. Include on any page containing a reference to such program an equally prominent statement to the effect that in providing supplemental coverage the insurer and agent involved in the solicitation is not in any manner connected with such program,

3. Contain a statement that it is an advertisement for insurance or is intended to obtain insurance prospects,

4. Prominently identify the insurer or insurers which issues the coverage, and

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5. Prominently state that any material or information offered will be delivered in person by a representative of the insurer, if such is the case.

(10) EXCEPTIONS, REDUCTIONS AND LIMITATIONS. (a) When an advertisement refers to any dollar amount of benefits payable, period of time for which any benefit is payable, cost of policy, specific policy benefit or the loss for which such benefit is payable, it shall also disclose those exceptions, reductions and limitations (including waiting, elimination, probationary or similar periods and pre−existing condition exceptions) affecting the basic provisions of the policy without which the advertisement would have the capacity and tendency to mislead or deceive subject to the following.

(b) An invitation to apply shall be subject to the disclosure requirements of this subsection.

(c) An invitation to inquire shall not be subject to the disclosure requirements of this subsection unless:

1. Such an advertisement mentions benefits, benefit periods or premiums for the purpose of doing more than identifying the policy or

2. Such an advertisement makes any reference to the policy's exceptions, reductions and limitations.

(d) A booklet, summary or explanation of coverage issued to insured persons shall be subject to the disclosure requirements of this subsection.

(e) An institutional advertisement shall not be subject to the disclosure requirements of this subsection.

(f) If the policy advertised does not provide immediate coverage for pre−existing conditions, an application or enrollment form contained in or included with an advertisement to be completed by the applicant and returned to the insurer shall contain a question or statement immediately preceding the applicant's signature line which summarizes the pre−existing condition provisions of the policy. The following are a suggested question and statement; however, an insurer shall use wording which is appropriate to the actual pre−existing condition provisions of the policy advertised: "Do you understand that the policy applied for will not pay benefits during the first − − − − − year(s) after the issue date for a disease or physical condition which you now have or have had in the past? Yes − − − − − −" or "I understand that the policy applied for will not pay benefits during the first − − − − − year(s) after the issue date for a disease or physical condition which I now have or have had in the past."

(g) An advertisement which is subject to the disclosure requirements of this subsection shall in negative terms disclose the extent to which any loss is not covered if the cause of the loss is a condition which exists prior to the effective date of the policy. The expression "pre−existing conditions"shall not be used unless appropriately defined.

(h) If a medical examination is required for a policy, an invitation to apply advertisement of such policy shall disclose such requirement.

(i) The exceptions, reductions and limitations referred to in this subsection shall include:

1. Those which are set out in the policy under captions referring to exceptions, reductions, limitations or exclusions or are otherwise designated as such, and

2. Those which are not so captioned or designated contained in other portions of the policy such as a benefit provision, definition or uniform provision.

(j) The following are examples of exceptions, reductions and limitations which generally *do* affect the basic policy provisions to such an extent that their absence would cause the advertisement to have the capacity and tendency to mislead or deceive.

1. War or act of war.

2. While in armed services.

3. Territorial restriction or coverage within United States and Canada.

4. Complete aviation exclusion.

5. Self−inflicted injury.

6. Injury inflicted by another person.

7. Time limitation on death, dismemberment or commencement of disability or medical treatment following an accident.

8. Pre−existing sickness or disease or other bodily infirmity.

9. Exclusion or reduction for loss due to specific diseases, classes of diseases or types of injuries.

10. Confinement restrictions in disability policies such as house confinement, bed confinement and confinement to the premises.

11. Waiting, elimination, probationary or similar periods.

12. Reduction in benefits because of age.

13. Any reduction in benefit during a period of disability.

14. Workers' compensation or employers' liability law exclusion.

15. Occupational exclusion.

16. Violation of law.

17. Automatic benefit in lieu of another benefit.

18. Confinement in government hospital.

19. Pregnancy.

20. Miscarriage in sickness or accident and sickness policy.

21. Restrictions relating to organs not common to both sexes.

22. Restrictions on number of hospital hours before benefit accrues.

23. Insanity, mental diseases or disorders or nervous disorder.

24. Dental treatment, surgery or procedures.

25. Cosmetic surgery.

26. While intoxicated or under the influence of narcotics, or other language not substantially the same as the uniform individual policy provision regarding the use of intoxicants and narcotics.

27. Unemployed persons.

28. Retired persons.

29. While handling explosives or chemical compounds.

30. While or as a result of participating in speed contests.

31. While or as a result of riding a motorcycle or motorcycle attachment.

32. While or as a result of participating in professional athletics.

33. While or as a result of participating in certain specified sports.

34. While or as a result of serving as a volunteer firefighter or in other hazardous occupations.

35. Riot or while participating in a riot.

36. Ptomaine poisoning.

37. Gas or poisonous vapor.

38. Sunstroke or heat prostration.

39. Freezing.

40. Poison ivy or fungus infection.

41. Requirement of permanent disability.

42. Reduction because of other insurance.

43. Limitations on the choice of providers or geographical area served.

(k) The following are examples of exceptions, reductions and limitations which generally *do not* affect the basic policy provisions to such an extent that their absence would cause the advertisement to have the capacity and tendency to mislead or deceive.

1. Suicide or attempted suicide, while sane or insane.

2. Intentional self−inflicted injury.

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3. Territorial restriction with no limitation of coverage while in United States and Canada.

4. Aviation exclusion under which passage on commercial airlines is covered.

5. Felony or illegal occupation.

6. All uniform individual policy provisions, both required and optional, other than those relating to other insurance.

7. Requirement for regular care by a physician.

8. Definition of total disability.

9. Definition of partial disability.

10. Definition of hospital.

11. Definition of specific total loss.

12. Definition of injury.

13. Definition of physician or surgeon.

14. Definition of nurse.

15. Definition of recurrent disability.

16. Definition of commercial air travel.

17. Provision that hernia will be considered a sickness.

18. Rest cure.

19. Diagnosis.

20. Prosthetics.

21. Cosmetic surgery exclusion under which such surgery which results from injury is covered.

22. Dental treatment, surgery or procedures exclusion under which such treatment which results from injury to sound natural teeth is covered.

23. Bacterial infection exclusion under which pyogenic infection which results from injury is covered.

24. Eye examination for fitting of glasses.

25. Hearing aid.

26. Exclusion of sickness or disease in a policy providing only accident coverage.

27. Exclusion for miscarriage in policy providing only accident coverage.

(11) RENEWABILITY, CANCELLABILITY AND TERMINATION. An advertisement shall disclose, as required below, the provisions relating to renewability, cancellability and termination and any modification of benefits, losses covered or premiums because of age or for other reasons, in a manner which shall not minimize or render obscure the qualifying conditions.

(a) Any advertisement which refers to renewability, cancellability or termination of a policy shall be subject to the disclosure requirements of this subsection.

(b) An advertisement which refers to a policy benefit and which is an invitation to apply shall be subject to the disclosure requirements of this subsection.

(c) An advertisement which refers to a policy benefit and which is an invitation to inquire shall not be subject to the disclosure requirements of this subsection unless:

1. Paragraph (a) or (f) applies or

2. Such an advertisement mentions benefits, benefit periods or premiums for the purpose of doing more than identifying the policy.

(d) A booklet, summary or explanation of coverage issued to insured persons shall be subject to the disclosure requirements of this subsection.

(e) An advertisement which refers to a policy benefit and which is an institutional advertisement shall not be subject to the disclosure requirements of this subsection unless par. (a) or (f) applies.

(f) An advertisement which states or illustrates time or age in connection with eligibility of applicants or continuation of the policy and which implies permanency shall be subject to the disclosure requirements of this subsection.

(g) The actual policy language concerning renewability, cancellability or termination need not be used in an advertisement subject to the disclosure requirements of this subsection. However, all pertinent information shall be disclosed.

(h) The qualifying conditions applicable to a non−cancellable policy and to a guaranteed renewable policy shall include age limits, aggregate benefit limits and modifications of benefits because of age, other than such modifications occurring at or about the time the policy terminates. A qualifying condition applicable to a guaranteed renewable policy shall be the insurer's reservation of the right to change premiums.

(i) The qualifying conditions shall be set forth with the language describing renewability.

(j) An advertisement of a group or blanket policy which would otherwise be subject to the disclosure requirements of this subsection need not disclose the policy's provisions relating to renewability, cancellability and termination. Such advertisement shall provide, however, as a minimum, that an insured person's coverage is contingent upon continued membership in the group and the continuation of the plan.

(k) An advertisement of a non−cancellable policy or of a guaranteed renewable policy shall also be subject to sub. (25).

(L) An advertisement of a franchise, wholesale, collectively renewable, or non−renewable for stated reasons only policy, or any other policy under which the insurer has by policy provision limited its right to terminate to one or more reasons, shall accurately set forth the policy's renewal provisions if disclosure of such renewal provisions is required by par. (a), (b), (c), (d) or (e). Such advertisement shall not state or imply renewal terms which are more favorable than those actually contained in the policy. Such advertisement shall not state or imply that the policy is guaranteed renewable or warranted renewable or that renewal is guaranteed or warranted or use other variations of such expressions.

(12) IDENTITY OF INSURER. (a) The identity of the insurer shall be made clear in all of its advertisements.

(b) An advertisement shall not use a trade name, an insurance group designation, the name of the parent company of the insurer, the name of a government agency or program, the name of a department or division of an insurer, the name of an agency, the name of any other organization, a service mark, a slogan, a symbol or any other device which has the capacity and tendency to mislead or deceive as to the identity of the insurer.

(c) An advertisement shall not use any combination of words, symbols or materials which, by its content, phraseology, shape, color, nature or other characteristics, is so similar to combinations of words, symbols or materials used by federal, state or local government agencies that it tends to confuse or mislead prospective buyers into believing that the solicitation is in some manner connected with such a government agency.

(d) An advertisement shall not refer to an affiliate of the insurer without disclosing that the 2 organizations are separate legal entities.

(e) An advertisement shall not indicate an address for an insurer in such a way as to mislead or deceive as to its identity or licensing status. An advertisement which indicates an address for an insurer other than that of its home office shall clearly identify such address and clearly disclose the actual city and state of domicile of the insurer.

(13) TESTIMONIALS, ENDORSEMENTS OR COMMENDATIONS BY THIRD PARTIES. (a) An advertisement shall not contain a testimonial, endorsement or other commendatory statement concerning the insurer, its policies or activities by any person who receives any pay or remuneration, directly or indirectly, from the insurer in connection with such testimonial, endorsement or statement. Any advertisement containing a testimonial, endorsement or statement not prohibited by the foregoing, shall include a full and prominent disclosure therein of the relationship, direct or indirect, including but not limited to financial interest and remuneration,

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between the insurer and the person making such testimonial, endorsement or statement. The provisions of this paragraph do not apply to any person holding a Wisconsin insurance agent's license nor to any radio or television announcer or other person employed or compensated on a salaried or union wage scale basis.

(b) A testimonial or endorsement used in an advertisement shall be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced.

(c) An insurer shall not use a testimonial or endorsement:

1. Which is fictional,

2. Where the insurer has information indicating a substantial change of view on the part of the author,

3. Where it is reasonable to conclude that the views expressed do not correctly reflect the current opinion of the author,

4. For more than 2 years after the date on which it was originally given or 2 years after the date of a prior confirmation without obtaining a confirmation that the statement represents the author's current opinion,

5. Which does not accurately reflect the present practices of the insurer,

6. To advertise a policy other than the one for which such statement was given, unless the statement clearly has some reasonable application to the second policy,

7. In which a change or omission has been effected which alters or distorts its meaning or intent as originally written, or

8. If it contains a description of benefit payments which does not disclose the true nature of the insurance coverage under which the benefits were paid.

(d) An advertisement shall not state or imply that an insurer or a policy has been approved or endorsed by an individual, group of individuals, society, association or other organization, unless such is the fact. Any proprietary relationship between such society, association or other organization and the insurer shall be disclosed. If such society, association or other organization has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, the advertisement shall clearly disclose such a fact.

(e) When a testimonial refers to benefits received under a policy, a summary of the pertinent claim information including claim number and date of loss shall be retained by the insurer with the advertisement in the advertising file required by sub. (28).

(f) An advertisement shall not state or imply that a government publication has commended or recommended the insurer or its policy.

(14) JURISDICTIONAL LICENSING; APPROVAL BY GOVERNMENTAL AGENCY. (a) An advertisement which may be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits.

(b) An advertisement shall not state or imply, or otherwise create the impression directly or indirectly, that the insurer, its financial condition or status, the payment of its claims, its policy forms or the merits or desirability of its policy forms or kinds or plans of insurance are approved, endorsed or accredited by any agency of this state or the federal government.

(c) In any advertisement any reference to licensing shall contain an appropriate disclaimer that such reference is not to be construed as an endorsement or implied endorsement of the insurer or its products by any agency of this state or the commissioner of insurance.

(d) An advertisement shall not contain a reproduction of a portion of a state insurance department report of examination.

(15) INTRODUCTORY, INITIAL OR SPECIAL OFFERS AND LIMITED ENROLLMENT PERIODS. (a) An advertisement shall not state or imply that a policy or combination of policies is an introductory, initial or special offer and that the applicant will receive advantages not available at a later date by accepting the offer, that only a limited number of policies will be sold, that a time is fixed for the discontinuance of the sale of the policy advertised because of special advantages available in the policy, or that an individual will receive special advantages by enrolling within an open enrollment period or by a deadline date, unless such is the fact.

(b) An advertisement shall not state or imply that enrollment under a policy is limited to a specific period unless the period of time permitted to enroll, which shall be not less than 10 days and not more than 40 days from the date of the advertisement, is disclosed.

(c) If the insurer making an introductory, initial or special offer has previously offered the same or similar policy on the same basis or intends to repeat the current offer for the same or similar policy, the advertisement shall so indicate.

(d) An insurer shall not establish for residents of this state a limited enrollment period within which an individual policy may be purchased less than 6 months after the close of an earlier limited enrollment period for the same or similar policy. Such restriction shall apply to all advertisements in newspapers, magazines and other periodicals circulated in this state, all mail advertisements sent to residents of this state and all radio and TV advertisements broadcast in this state. Such restriction shall not apply to the solicitation of enrollments under individual policies issued on a group basis.

(e) Where an insurer is an affiliate of a group of insurers under common management and control, the word "insurer" for the purposes of this subsection means the insurance group. The requirements and restrictions applicable to an insurer shall apply to the insurance group.

(f) Similar policies for the purposes of this subsection include policies which provide similar benefits even though there may be differences in benefit amounts, elimination periods, renewal terms or ancillary benefits.

(16) MAIL ORDER REFUSAL FORM. An insurer shall not use a mail order advertisement which requires the recipient, in order to refuse a policy, to sign a refusal form and return it to the insurer.

(17) GROUP, QUASI–GROUP OR SPECIAL CLASS IMPLICATIONS. An advertisement shall not state or imply that prospective policyholders or members of a particular class of individuals become group or quasi–group members or are uniquely eligible for a special policy or coverage and as such will be subject to special rates or underwriting privileges or that a particular coverage or policy is exclusively for preferred risks, a particular segment of people, or a particular age group or groups, unless such is the fact.

(18) INSPECTION OF POLICY. (a) An offer in an advertisement of free inspection of a policy or an offer of a premium refund shall not be a cure for misleading or deceptive statements contained in such advertisement.

(b) An advertisement which refers to the provision in the policy advertised regarding the right to return the policy shall disclose the time limitation applicable to such right.

(19) IDENTIFICATION OF PLAN OR NUMBER OF POLICIES. (a) When an advertisement refers to a choice regarding benefit amounts, it shall disclose that the benefit amounts provided will depend upon the plan selected and that the premium will vary with the amount of the benefits.

(b) When an advertisement refers to various benefits which may be contained in 2 or more policies, other than group policies, it shall disclose that such benefits are provided only through a combination of such policies.

(20) USE OF STATISTICS. (a) An advertisement which sets out the dollar amounts of claims paid, the number of persons insured or other statistical information shall identify the source of such statistical information and shall not be used unless it accurately reflects all of the relevant facts. Irrelevant statistical data shall not be used.

(b) An advertisement shall not imply that the statistical information given is derived from the insurer's experience under the

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policy advertised unless such is the fact. The advertisement shall specifically so state if such information applies to other policies or plans.

(c) If a loss ratio is to be shown in an advertisement, it shall be derived from either premiums received and benefits paid or premiums earned and losses incurred.

(d) If loss ratios are to be compared between insurers in an advertisement, comparison shall be limited to policies or plans of the same type issued to similar classes of risks.

(e) An advertisement which sets out the dollar amounts of claims paid shall also indicate the period during which such claims have been paid.

(21) SERVICE FACILITIES. An advertisement shall not:

(a) Contain untrue statements with respect to the time within which claims are paid.

(b) State or imply that claim settlements will be liberal or generous or use words of similar import.

(c) State or imply that claim settlements will be beyond the actual terms of the policy, or

(d) Contain a description of a claim which involves unique or highly unusual circumstances.

(22) STATEMENTS ABOUT AN INSURER. An advertisement shall not contain statements which are untrue in fact or are by implication misleading with respect to the insurer's assets, corporate structure, financial standing, age, experience or relative position in the insurance business.

(23) DISPARAGING COMPARISONS AND STATEMENTS. An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits and shall not falsely or unfairly disparage, discredit or criticize competitors, their policies, services or business methods or competing marketing methods.

(24) METHOD OF DISCLOSURE OF REQUIRED INFORMATION. (a) All information required to be disclosed by this rule shall be set out clearly, conspicuously and in close conjunction with the statements to which such information relates or under appropriate captions of such prominence that it shall be readily noticed and not minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisements so as to be confusing or misleading.

(b) An advertisement or representation of a specific individual policy or policies which constitutes an invitation to apply shall include an outline of coverage as required by sub. (8).

(c) Information required by this rule shall not be set out under inappropriate captions or headings or under inappropriate questions where a question and answer format is used.

(d) An advertisement of a hospital confinement indemnity policy shall disclose in close conjunction with any description of the benefits the existence in the policy of a provision which eliminates benefits for sickness and/or injury conditions for a stated number of days at the beginning of a hospital confinement.

(e) An advertisement of a non−cancellable policy or of a guaranteed renewable policy shall also be subject to sub. (25).

(25) NON−CANCELLABLE AND GUARANTEED RENEWABLE POLICIES. (a) No person, in the presentation, solicitation, effectuation, or sale of a policy, and no advertisement, relating to or used in connection with a policy, shall use the terms "non−cancellable" or "non−cancellable and guaranteed renewable" or "guaranteed renewable", except in connection with policies conforming to s. Ins 3.13 (2) (e).

(b) An advertisement describing a non−cancellable and guaranteed renewable or guaranteed renewable policy form shall be subject to sub. (11).

(c) A printed advertisement describing a non−cancellable or non−cancellable and guaranteed renewable policy form shall disclose, as prominently as and in close conjunction with any prominent use of the terms"non−cancellable" or "non−cancellable and guaranteed renewable":

1. The age to or term for which the form is non−cancellable or non−cancellable and guaranteed renewable, if other than lifetime,

2. The age or time at which the form's benefits are reduced, if applicable, (the age or time at which a form's benefits are reduced need not be so disclosed if such reduction is not effected prior to the age to or term for which the form is non−cancellable or non−cancellable and guaranteed renewable or if regular benefits are payable at least to the age to or term for which the form is non−cancellable or non−cancellable and guaranteed renewable), and

3. That benefit payments are subject to an aggregate limit, if applicable.

(d) A printed advertisement describing a guaranteed renewable policy form shall disclose, as prominently as and in close conjunction with any prominent use of the term "guaranteed renewable":

1. The age to or term for which the form is guaranteed renewable, if other than lifetime,

2. The age or time at which the form's benefits are reduced, if applicable, (the age or time at which a form's benefits are reduced need not be so disclosed if such reduction is not effected prior to the age to or form for which the form is guaranteed renewable or if regular benefits are payable at least to the age to or term for which the form is guaranteed renewable)

3. That benefit payments are subject to an aggregate limit, if applicable, and

4. That the applicable premium rates may be changed.

(e) The foregoing limitations on the use of the term "non−cancellable"shall also apply to any synonymous term such as "not cancellable"; and the foregoing limitations on use of the term "guaranteed renewable" shall apply to any synonymous term such as "guaranteed continuable".

(26) FORM NUMBER. An advertisement which is an invitation to apply or an invitation to inquire and which is mass−produced shall be identified by a form number. The form number shall be sufficient to distinguish it from any other advertising form or any policy, application or other form used by the insurer.

(27) INSURER'S RESPONSIBILITY FOR ADVERTISEMENTS. (a) The content, form and method of dissemination of all advertisements, regardless of by whom designed, created, written, printed or used, shall be the responsibility of the insurer whose policy is advertised.

(b) An insurer shall require its agents and any other person or agency acting on its behalf in preparing advertisements to submit proposed advertisements to it for approval prior to use.

(28) INSURER'S ADVERTISING FILE. Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its policies hereafter disseminated in this or any other state, whether or not licensed in such other state. With respect to group, blanket and franchise policies, all proposals prepared on the same printed form need not be included in the file; only typical examples of such proposals need be included. A notation shall be attached to each such advertisement in the file indicating the manner and extent of distribution and the form number of any policy, amendment, rider, or endorsement form advertised. A copy of the policy advertised, together with any amendment, rider or endorsement applicable thereto, shall be included in the file with each such advertisement. Such file shall be subject to regular and periodic inspection by the office of the commissioner of insurance. All such advertisements shall be maintained in such file for a period of 4 years or until the filing of the next regular examination report on the insurer, whichever is the longer period.

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(29) PENALTY. Violations of this rule shall subject the violator to s. 601.64, Stats.

(31) EFFECTIVE DATE. This rule shall apply to all advertisements used in this state after June 1, 1973.

History: Cr. Register, April, 1973, No. 208, eff. 6−1−73; am. (zb), (11) (c) 1. and (11) (e), Register, August, 1973, No.212, eff. 9−1−73; am. (5) (b) 1., Register, April, 1975, No. 232, eff. 5−1−75; emerg. am. (1), (2), (5) (c) and (m) 1., eff. 6−22−76; am. (1), (2), (5) (c) and (m) 1., Register, September, 1976, No. 249, eff. 10−1−76; cr. (9) (zh), Register, November, 1976, No. 251, eff. 12−1−76; am. (2), Register, March, 1979, No. 279, eff. 4−1−79; r. (29), Register, March, 1981, No. 303, eff. 4−1−81; cr. (10) (j) 43., Register, October, 1984, No. 346, eff. 11−1−84; r. (30) under s. 13.93 (2m) (b) 16., Stats., Register, December, 1984, No. 348; am. (4) (a), (9) (p) and (v) (intro.) and (10) (h), Register, March, 1985, No. 351, eff. 4−1−85; correction in (2) (and (5) made under s. 13.93 (2m) (b) 7., Stats., Register, April, 1992, No. 436; am. (5) (a) 1., Register, January, 1999, No. 517, eff. 2−1−99.

Ins 3.28 Solicitation, underwriting and claims practices in individual and franchise accident and sickness insurance. (1) PURPOSE. The purpose of this rule is to promote the fair and equitable treatment of Wisconsin residents in the solicitation, underwriting and administration of accident and sickness insurance and of contracts issued by a plan subject to ch. 613, Stats. Sections of statutes interpreted or implemented by this rule include but are not limited to ss. 601.04 (3), 601.01 (2), 611.20, 618.12 (1), and 632.76, Stats.

(2) SCOPE. This rule applies to the solicitation, underwriting and administration of any insurance issued by any insurer or fraternal benefit society under s. Ins 6.75 (1) (c) or (2) (c) and ss. 600.03 (22) and 632.93, Stats., except credit accident and sickness insurance under s. Ins 6.75 (1) (c) 1. or (2) (c) 1., and to any contract, other than one issued on a group or group type basis as defined in s. Ins 6.51 (3), issued by a plan subject to ch. 613, Stats. For the purpose of this rule, references to insurer, policy, and insurance agent or representative, also apply to organizations or associations operating non−profit plans, contracts, and persons within the scope of the rule, respectively.

(3) APPLICATION FORM. An application form which becomes part of the insurance contract shall provide to the effect that statements made by the applicant in the application form regarding the general medical history or general health of a proposed insured person which require an opinion or the exercise of judgment are representations or are to the best of the applicant's knowledge and/or belief. Such form need not so provide with respect to statements regarding specifically named diseases, physical conditions, or types of medical consultation or treatment. Such form shall not require the applicant to state that he or she has not withheld any information or concealed any facts in completing the application; however, the applicant may be required to state that his or her answers are true and complete to the best of his or her knowledge and/or belief.

(4) SOLICITATION. An insurance agent or representative shall review carefully with the applicant all questions contained in each application which he or she prepares and shall set down in each such form all material information disclosed to him or her by the applicant in response to the questions in such form.

(5) UNDERWRITING. (a) An insurer shall make provision for adequate underwriting personnel and procedures so as to process without undue delay each application for insurance received by it.

(b) An insurer shall give due consideration to all statements in each application for insurance submitted to it and shall duly evaluate the proposed insured person before issuing coverage for such person.

(c) An insurer which issues coverage for a person shall not use the statements, information or material set out in subds. 1., 2. and 3. to void the coverage on the basis of misrepresentation in the application, or deny a claim on the basis of a pre−existing condition defense, unless the insurer has:

1. Resolved patently conflicting or incomplete statements in the application for the coverage;

2. Duly considered information furnished to it:

a. In connection with the processing of such application, or

b. In connection with individual coverage on the person previously issued by it and currently in force, or

3. Duly considered the material which it would have obtained through reasonable inquiry following due consideration of the statements or information.

(d) An insurer shall at the issuance or amendment of a policy, contract or subscriber certificate, furnish notice concerning statements in the application to the policyholder, contracting party or certificate holder, where the application for the coverage or amended coverage contains questions relating to the medical history or other matters concerning the insurability of the person or persons being insured and the application is part of the insurance contract.

1. The notice shall be printed prominently in contrasting color on the first page of the policy, contract, or subscriber certificate or in the form of a sticker, letter or other form attached to the first page of the policy, contract or certificate, or a letter or other form to be mailed within 10 days after the issuance or amendment of coverage.

2. The notice shall contain substantially the following as to text and caption or title:

IMPORTANT NOTICE CONCERNING STATEMENTS IN THE APPLICATION FOR YOUR INSURANCE

Please read the copy of the application attached to this notice or to your policy. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to the insurer within 10 days if any information shown on the application is not correct and complete or if any medical history has not been included. The application is part of the insurance contract. The insurance contract was issued on the basis that the answers to all questions and any other material information shown on the application are correct and complete.

(e) An insurer shall file with the commissioner a description of the procedure it will follow and the form or forms it will use to meet the requirements of par. (d).

(f) An insurer which, after coverage for a person has been issued, receives information regarding such person which would reasonably be considered a sufficient basis to void or reform such person's coverage shall effect such voiding or reformation as provided in s. 631.11 (4), Stats., or the insurer shall be held to have waived its rights to such action.

(g) An insurer may use statements in an application form as a defense to a claim or to avoid or reform coverage only if it has complied with par. (d).

(6) CLAIMS ADMINISTRATION. (a) If the existence of a disease or physical condition is duly disclosed in the application for coverage in response to the questions therein, the insurer shall not use the pre−existence defense, under coverage providing such a defense, to deny benefits for such disease or condition unless such disease or condition is excluded from coverage by name or specific description effective on the date of loss. This paragraph does not apply to a preexisting condition exclusion permitted under s. 632.746 (1), Stats.

(b) If an application contains no question concerning the proposed insured person's health history or medical treatment history and regardless of whether it contains a question concerning the proposed insured person's general health at the time of the application, the insurer may use the pre−existence defense, under coverage providing such a defense, only with respect to losses incurred or disability commencing within 12 months from the effective date of coverage, unless the disease or physical condition causing the loss or disability is excluded from coverage by name or specific description effective on the date of loss or the date the disability commenced. If, after 12 months from the effective date of coverage, there is a reoccurrence of the disease or condition causing the loss or disability, then the pre−existence defense may not be used. Under a disability income policy a dis-

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ease or condition shall be deemed to have not reoccurred if the insured performs all important duties of the insured's or a comparable occupation on the same basis as before the disability, for at least 6 months. Under a policy other than disability income a disease or condition shall be deemed to have not reoccurred if a period of 6 months elapses during which no expenses are incurred for the same or related disease or condition.

(c) An insurer shall not void coverage or deny a claim on the ground that the application for such coverage did not disclose certain information considered material to the risk if the application did not clearly require the disclosure of such information.

(d) A claim shall not be reduced or denied on the grounds that the disease or physical condition resulting in the loss or disability had existed prior to the effective date of coverage, under coverage providing such a defense, unless the insurer has evidence that such disease or physical condition, as distinguished from the cause of such disease or physical condition, had manifested itself prior to such date. Such manifestation may be established by evidence of:

1. Medical diagnosis or treatment of such disease or physical condition prior to the effective date, or

2. The existence of symptoms of such disease or physical condition prior to the effective date which would cause an ordinarily prudent person to seek diagnosis, care or treatment and for which such diagnosis, care or treatment was not sought prior to such date.

(e) Coverage which contains wording which requires the cause of the disease or physical condition, as distinguished from the disease or physical condition itself, to originate after the effective date of coverage shall be administered in accordance with par. (d).

(f) An insurer shall not exclude or limit benefits for a particular condition where the claimant's medical records indicate a reasonable basis for, and the policy language permits, distinguishing between the eligible condition or conditions which necessitated the hospital confinement or medical or surgical treatment for which claim is made, or which resulted in the disability for which the claim is made, and a concurrently non−eligible existing condition or conditions which did not contribute to the need for the confinement or treatment, or contribute to the disability. The exclusion or limitation of benefits includes the use of:

1. A pre−existence defense;

2. A waiting period, such as for pregnancy, surgery or other stated condition or procedure;

3. A benefit maximum; or

4. Other policy limitation.

(7) EFFECTIVE DATE. (a) Subsections (4), (5) (a), (b), (c), and (f) and (6) shall apply to all solicitation, underwriting, and claims activities, except under franchise insurance, relating to Wisconsin residents after March 1, 1974, except that sub. (6) (a) and (b) shall apply to policies issued after that date.

(b) Subsections (3) and (5) (d) and (e) shall apply to all solicitation, underwriting, and claims activities, except under franchise insurance, relating to Wisconsin residents after May 1, 1974.

(c) This rule shall apply to all solicitation, underwriting and claims activities under franchise insurance relating to Wisconsin residents after December 1, 1974, except that sub. (6) (a) and (b) shall apply to policies issued after that date and sub. (5) (d) and (e) shall apply to such activities after February 1, 1975.

History: Cr. Register, February, 1974, No. 218, eff. 3−1−74; am. (5) (d) (intro. par.), Register, July, 1974, No. 223, eff. 8−1−74; am. (2) and (7), Register, November, 1974, No. 227, eff. 12−1−74; emerg. am. (1) and (2), eff. 6−22−76; am. (1) and (2), Register, September, 1976, No. 249, eff. 10−1−76; am. (1) and (2), Register, March, 1979, No. 279, eff. 4−1−79; am. (1), (2), (5) (f) and (6) (b), cr. (5) (g), r. and recr. (5) (c) and (d) and (6) (d) and (f), Register, April, 1982, No. 316, eff. 5−1−82; correction in (1) and (2) made under s. 13.93 (2m) (b) 7., Stats., Register, April, 1992, No. 436; am. (6) (a), Register, November, 1993, No. 455, eff. 2−1−94; correction in (6) (a) made under s. 13.93 (2m) (b) 7., Stats., Register, July, 1999, No. 523.

Ins 3.29 Replacement of accident and sickness insurance. (1) PURPOSE. The purpose of this section is to safeguard the interests of persons covered under accident and sickness insurance who consider the replacement of their insurance by making available to them information regarding replacement and thereby reducing the opportunity for misrepresentation and other unfair practices and methods of competition in the business of insurance. This section implements and interprets ss. 601.01 (2) and 628.34, Stats.

(2) SCOPE. This rule shall apply to the solicitation of accident and sickness insurance covering residents of this state and issued by insurance corporations, fraternal benefit societies or nonprofit service plans in accordance with s. Ins 6.75 (1) (c) or (2) (c), s. 614.01, Stats., and ch. 613, Stats.

(3) EXEMPT INSURANCE. This rule shall not apply to the solicitation of the following accident and sickness insurance:

(a) Group, blanket or group type, except Medicare supplement and replacement insurance subject to s. Ins 3.39 (4), (4s), (5), (5m) and (7).

(b) Accident only.

(c) Single premium nonrenewable.

(d) Nonprofit dental care.

(e) Nonprofit prepaid optometric service.

(f) A limited policy conforming to s. Ins 3.13 (2) (h).

(g) Under which dental expenses only, prescription expenses only, vision care expenses only or blood service expenses only are covered.

(h) Conversion to another individual or family policy in the same insurer with continuous coverage.

(i) Conversion to an individual or family policy to replace group, blanket or group type coverage in the same insurer.

(4) DEFINITIONS. For the purposes of this rule:

(a) "Replacement" is any transaction wherein new accident and sickness insurance is to be purchased, and it is known to the agent or company at the time of application that as part of the transaction, existing accident and sickness insurance has been or is to be lapsed or the benefits thereof substantially reduced.

(b) "Continuous coverage" means that the benefits are not less than the benefits under the previous policy, and the policy also covers loss resulting from injury sustained or sickness contracted while coverage was in force under the previous policy to the extent such loss is not covered under any extended benefit or similar provision of the previous policy.

(c) "Group type coverage" is as defined in s. Ins 6.51 (3).

(d) "Direct response insurance" is insurance issued to an applicant who has completed the application and forwarded it directly to the insurer in response to a solicitation coming into his or her possession by any means of mass communication.

(5) REPLACEMENT QUESTION IN APPLICATION FORMS. An application form for insurance subject to this rule shall contain a question to elicit information as to whether the insurance to be issued is to replace any insurance presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

(6) NOTICE TO BE FURNISHED. (a) An agent soliciting the sale of insurance shall, upon determining that the sale would involve replacement, furnish to the applicant, at the time of taking the application, the notice described in sub. (7) to be signed by the applicant.

(b) An insurer soliciting direct response insurance shall, upon determining that the sale would involve replacement, furnish to the applicant, before the policy is issued, the notice described in sub. (7) to be signed by the applicant.

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(c) A copy of such notice shall be left with or retained by the applicant and a signed copy shall be retained by the insurer.

(7) NOTICE TO APPLICANT. (a) The notice required by sub. (6) shall provide, in substantially the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to (your application) (the information furnished by you), you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by _____ Insurance Company. For your own information and protection, certain facts should be pointed out to you which should be considered before you make this change.

1. Health conditions which you may presently have may not be covered under the new policy. This could result in a claim for benefits being denied which may have been payable under your present policy. (This language may be modified if pre−existing conditions are covered under the new policy.)

2. Even though some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective. (This language may be modified if pre−existing conditions are covered under the new policy.)

3. Questions in the application for the new policy must be answered truthfully and completely; otherwise, the validity of the policy and the payment of any benefits thereunder may be voided.

4. The new policy will be issued at a higher age than that used for issuance of your present policy; therefore, the cost of the new policy, depending upon the benefits, may be higher than you are paying for your present policy.

5. The renewal provisions of the new policy should be reviewed so as to make sure of your rights to periodically renew the policy.

6. It may be to your advantage to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. You should be certain that you understand all the relevant factors involved in replacing your present coverage. The above "Notice to Applicant" was delivered to me on

_____
Date

_____
Applicant

(b) The notice required by sub. (6) for a Medicare supplement policy subject to s. Ins 3.39 (4), (4s), (5), (5m), and (7), shall include an introductory statement in substantially the following form: Your new policy provides _____ days within which you may decide without cost whether you desire to keep the policy.

(8) VIOLATION. A violation of this rule shall be considered to be a misrepresentation for the purpose of inducing a person to purchase insurance. A person guilty of such violation shall be subject to s. 601.64, Stats.

(10) EFFECTIVE DATE. This rule shall become effective September 1, 1974.

History: Cr. Register, June, 1974, No. 222, eff. 9−1−74; emerg. am. (1) and (2), eff. 6−22−76; am. (1) and (2), Register, September, 1976, No. 249, eff. 10−1−76; am. (2), Register, March, 1979, No. 279, eff. 4−1−79; am. (3) (a) and (i), r. (3) (j), renum. (7) to be (7) (a) and am., cr. (7) (b), Register, June, 1982, No. 318, eff. 7−1−82; r. (9) under s. 13.93 (2m) (b) 16., Stats., Register, December, 1984, No. 348; corrections in (1), (3) (a) and (4) (d) made under s. 13.93 (2m) (b) 5. and 7., Stats., Register, April, 1992, No. 436; CR 08−112: am. (3) (a) and (7) (b) Register June 2009 No. 642, eff. 7−1−09.

Ins 3.30 Change of beneficiary and related provisions in accident and sickness insurance policies. (1) PURPOSE. The purpose of this rule is to establish guidelines for wording change of beneficiary provisions and related provisions in accident and sickness insurance policies.

(2) SCOPE. This rule shall apply to policy forms subject to s. Ins 6.75 (1) (c) or (2) (c) and s. 600.03 (4), (22) and (23), Stats.

(3) GUIDELINES. A change of beneficiary provisions and any related provision:

(a) Shall comply with s. 632.71, Stats., except as provided in ss. 631.81 and 632.77 (4), Stats., where applicable, and

(b) May include requirements or limitations which would be consistent with an orderly method of handling beneficiary designations and changes such as

1. A requirement that a beneficiary designation or change be recorded by the insurer,

2. A provision that a claim payment made before a change in beneficiary designation is recorded is not subject to such change,

3. A requirement that a beneficiary designation or change be written as opposed to oral, or

4. A requirement that a beneficiary designation or change be given to a particular agent, representative or office.

History: Cr. Register, May, 1974, No. 221, eff. 6−1−74; emerg. am. (2) and (3) (a), eff. 6−22−76; am. (2) and (3) (a), Register, September, 1976, No. 249, eff. 10−1−76; am. (2) and (3) (a), Register, March, 1979, No. 279, eff. 4−1−79; correction in (2) made under s. 13.93 (2m) (b) 7., Stats., Register, April, 1992, No. 436.

Ins 3.31 Eligibility for and solicitation, underwriting and claims practices in group, blanket and group type accident and sickness insurance. (1) PURPOSE. The purpose of this rule is to promote the fair and equitable treatment of Wisconsin residents in the solicitation, underwriting and administration of accident and sickness insurance and coverage issued by a plan subject to s. 185.981, Stats., or ch. 613, Stats. Sections of Statutes interpreted or implemented by this rule include but are not limited to ss. 601.04 (3), 601.01 (2), 611.20, 618.12 (1) and 632.76, Stats.

(2) SCOPE. This rule applies to the solicitation, underwriting and administration of insurance issued by an insurer under s. 600.03 (4) or (23), Stats., except credit accident and sickness insurance under s. Ins 6.75 (1) (c) 1. or (2) (c) 1., and coverage issued on a group basis or group type basis as defined in s. Ins 6.51 (3) by a plan subject to s. 185.981, Stats., or ch. 613, Stats. For the purposes of this rule, references to insurer, certificate, insurance agent or representative, enrollment form and enrollee also apply to organizations or associations operating non−profit plans, contracts, summaries of coverage, persons within the scope of the rule, individual applications and applicants, respectively.

(3) GROUP AND GROUP TYPE INSURANCE. An insurer issuing insurance under s. 600.03 (23), Stats., or group or group type coverage under s. 185.981 or ch. 613, Stats., shall,

(a) Where the enrollment form contains questions relating to the medical history of the person or persons to be covered, be subject to the following:

1. Enrollment form. An enrollment form shall provide to the effect that statements made by the enrollee in the enrollment form regarding the general medical history or general health of the proposed insured person which require an opinion or the exercise of judgment are representations or are to the best of the enrollee's knowledge and/or belief. Such form need not so provide with respect to statements regarding specifically named diseases, physical conditions, or types of medical consultation or treatment. Such forms shall not require the enrollee to state that he or she has not withheld any information or concealed any facts in completing the enrollment form; however, the enrollee may be required to state that his or her answers are true and complete.

2. Solicitation. An insurance agent or representative shall review carefully with the enrollee all questions contained in each enrollment form which he or she prepares and shall set down in each such form all material information disclosed to him or her by the enrollee in response to the questions in such form. This does not require that an insurance agent or representative prepare or assist in the preparation of each enrollment form.

3. Underwriting. a. An insurer shall make provision for adequate underwriting personnel and procedures so as to process

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without undue delay each enrollment form for insurance received by it.

b. An insurer shall give due consideration to all statements in each enrollment form for insurance submitted to it and shall duly evaluate the proposed insured person before issuing evidence of coverage for such person.

c. An insurer which issues evidence of coverage for a person shall not use the statements, information or material set out in subds. 1., 2. and 3. to void the coverage on the basis of misrepresentation in the enrollment form, or deny a claim on the basis of a pre−existing condition defense, unless the insurer has resolved patently conflicting or incomplete statements in the enrollment form for the coverage, duly considered information furnished to it in connection with the processing of such enrollment form, or duly considered the material which it would have obtained through reasonable inquiry following due consideration of such statements or information.

d. An insurer shall furnish to the certificate holder or subscriber a notice printed prominently in contrasting color on the first page of the certificate or amendment, or in the form of a sticker or other form to be attached to the first page of the certificate or amendment, or furnish to the group policyholder or other such entity within 10 days after the issuance or amendment of coverage for delivery to the certificate holder or subscriber, a notice in the form of a letter or other form, such notice to contain substantially the following:

IMPORTANT NOTICE CONCERNING STATEMENTS IN THE ENROLLMENT FORM FOR YOUR INSURANCE

Please read the copy of the enrollment form attached to this notice or to your certificate or which has been otherwise previously delivered to you by the insurer or group policyholder. Omissions or misstatements in the enrollment form could cause an otherwise valid claim to be denied. Carefully check the enrollment form and write to the insurer within 10 days if any information shown on the form is not correct and complete or if any requested medical history has not been included. The insurance coverage was issued on the basis that the answers to all questions and any other material information shown on the enrollment form are correct and complete.

e. An insurer shall file with the commissioner a description of the procedure it will follow and the form or forms it will use to meet the requirements of subd. 3. d.

f. An insurer which, after evidence of coverage for a person has been issued, receives information regarding such person which would reasonably be considered a sufficient basis to void or reform such person's coverage, shall effect such voiding or reformation, as provided in s. 631.11 (4), Stats., or the insurer shall be held to have waived its rights to such action.

g. An insurer may use statements in an enrollment form as a defense to the claim or to void or reform coverage only if it has complied with the requirements of subd. 3. d.

4. Claims administration. a. If the existence of a disease or physical condition was duly disclosed in the enrollment form for coverage in response to the questions therein, the insurer shall not use the pre−existence defense, under coverage providing such a defense, to deny benefits for such disease or condition unless such disease or condition is excluded from coverage by name or specific description effective on the date of loss. This paragraph does not apply to a preexisting condition exclusion permitted under s. 632.746 (1), Stats.

b. If an enrollment form contains no question concerning the proposed insured person's health history or medical treatment history and regardless of whether it contains a question concerning the proposed insured person's general health at the time of enrollment, the insurer may use the pre−existence defense, under coverage providing such a defense, only with respect to losses incurred or disability commencing within 12 months from the effective date of the person's coverage, unless the disease or physical condition causing the loss or disability is excluded from coverage by name or specific description effective on the date of loss or the date the disability commenced. If after 12 months from the effective date of coverage, there is a reoccurrence of the disease or condition causing the loss or disability, then the pre−existence defense may not be used. Under a disability income policy a disease or condition shall be deemed to have not reoccurred if the insured performs all important duties of a comparable occupation on the same basis as before the disability, for at least 6 months. Under a policy other than disability income a disease or condition shall be deemed to have not reoccurred if a period of 6 months elapses during which no expenses are incurred for the same or a related disease or condition.

c. An insurer shall not void coverage or deny a claim on the ground that the enrollment form for such coverage did not disclose certain information considered material to the risk if the form did not clearly require the disclosure of such information.

(b) Be subject to the following:

1. A claim shall not be reduced or denied on the grounds that the disease or physical condition resulting in the loss or disability had existed prior to the effective date of coverage, under coverage providing such a defense, unless the insurer has evidence that such disease or physical condition, as distinguished from the cause of such disease or physical condition, had manifested itself prior to such date. Such manifestation may be established by evidence of:

a. Medical diagnosis or treatment of such disease or physical condition prior to the effective date, or

b. The existence of symptoms of such disease or physical condition prior to the effective date which would cause an ordinarily prudent person to seek diagnosis, care, or treatment and for which such diagnosis, care or treatment was not sought prior to such date.

2. Coverage which contains wording which requires the cause of the disease or physical condition, as distinguished from the disease or physical condition itself, to originate after the effective date of coverage shall be administered in accordance with subd. 1.

3. An insurer shall not exclude or limit benefits for a particular condition where the claimant's medical records indicate a reasonable basis for, and the policy language permits, distinguishing between the eligible condition or conditions which necessitated the hospital confinement or medical or surgical treatment for which claim is made, or which resulted in the disability for which the claim is made, and a concurrently non−eligible existing condition or conditions which did not contribute to the need for the confinement or treatment, or contribute to the disability. The exclusion or limitation of benefits includes the use of:

a. A pre−existence defense;

b. A waiting period, such as for pregnancy, surgery or other stated condition or procedure;

c. A benefit maximum; or

d. Other policy limitation.

(c) Where the group or group type plan is issued to trustees of a fund, use the plan's provisions regarding individual eligibility for coverage and individual termination of coverage to deny liability for or to defend against a claim only if the certificate issued pursuant to the plan, under an appropriate caption or captions, includes the applicable requirements regarding an individual's eligibility for coverage and the conditions under which an individual's coverage terminates under the plan.

(4) BLANKET INSURANCE. An insurer issuing insurance under s. 600.03 (4), Stats., shall

(a) Include in an enrollment form used in connection with such insurance no question relating to the medical history or other matter concerning the insurability of the person or persons to be insured and

(b) Be subject to the following:

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1. A claim shall not be reduced or denied on the grounds that the disease or physical condition resulting in the loss or disability had existed prior to the effective date of coverage, under coverage providing such a defense, unless the insurer has evidence that such disease or physical condition had manifested itself prior to such date. Such manifestation may be established by evidence of:

a. Medical diagnosis or treatment of such disease or physical condition prior to the effective date, or

b. The existence of symptoms of such disease or physical condition prior to the effective date which would cause an ordinarily prudent person to seek diagnosis, care or treatment and for which such diagnosis, care or treatment was not sought prior to such date.

2. Coverage which contains wording which requires the cause of the disease or physical condition, as distinguished from the disease or physical condition itself, to originate after the effective date of coverage shall be administered in accordance with subd. 1. b.

3. An insurer shall not exclude or limit benefits for a particular condition where the claimant's medical records indicate a reasonable basis for, and the policy language permits, distinguishing between the eligible condition or conditions which necessitated the hospital confinement or medical or surgical treatment for which claim is made, or which resulted in the disability for which the claim is made, and a concurrently non−eligible existing condition or conditions which did not contribute to the need for the confinement or treatment, or contribute to the disability. The exclusion or limitation of benefits includes the use of:

a. A pre−existence defense;

b. A waiting period, such as for pregnancy, surgery or other stated condition or procedure;

c. A benefit maximum; or

d. Other policy limitation.

(5) EFFECTIVE DATE. This rule shall apply to all solicitation, underwriting, and claims activities relating to Wisconsin residents after December 1, 1974, except that sub. (3) (a) 4. a. and b. shall apply to coverage issued after said date and sub. (3) (a) 3. d., e. and g. shall apply to such activities after February 1, 1975.

History: Cr. Register, November, 1974, No. 227, eff. 12−1−74; emerg. am. (1), (2), (3) (intro.) and (c) and (4), eff. 6−22−76; am. (1), (2), (3) (intro.) and (c) and (4), Register, September, 1976, No. 249, eff. 10−1−76; am. (1) and (2), Register, March, 1979, No. 279, eff. 4−1−79; am. (1), (2), (3) (intro.), (3) (a) 3. d., f. and 4. b., (3) (c) and (4), r. and recr. (3) (a) 3. c., (3) (b) 1. and 3., (4) (b) 1. and 3., Register, April, 1982, No. 316, eff. 5−1−82; correction in (2) and (3) (intro.) made under s. 13.93 (2m) (b) 7., Stats., Register, April, 1992, No. 436; am. (3) (a) 4. a., Register, November, 1993, No. 455, eff. 2−1−94; correction in (3) (a) 4. a. and (4) (intro.) made under s. 13.93 (2m) (b) 7., Stats., Register, July, 1999, No. 523.

Ins 3.32 Title insurance; prohibited practices. (1) PURPOSE. This rule implements and interprets s. 601.01 (3), Stats., and ch. 628, Stats., for the purpose of prohibiting unfair practices in the transaction of the business of title insurance.

(2) SCOPE. This section applies to all title insurers and title insurance agents.

(3) DEFINITIONS. In this section:

(a) "Affiliate" has the meaning provided under s. 600.03 (1), Stats.

(am) "Agent" has the meaning provided under s. 600.03 (1r), Stats.

(b) "Affiliate producer" means an affiliate of a producer of title insurance, but only for the 12−month period commencing after June 30, 1987, and after the end of any quarter calendar year in which the affiliate's gross revenue from operation in this state from title insurance directly or indirectly referred by affiliated producers of title insurance exceeds 40% of the affiliate's gross revenue from operations in this state for title insurance in the previous quarter calendar year. However, if the previous quarter calendar year commences prior to July 1, 1988, the percentage is 80%; and if it commences prior to July 1, 1989, the percentage is 60%. "Affiliate producer"does not include a person who is affiliated with producers of title insurance who are all attorneys if the affiliate examines the title for each title insurance policy it issues.

(bm) "Control" has the meaning provided under s. 600.03 (13), Stats.

(c) "Producer of title insurance" means any of the following, other than a title insurer, who order or influence, directly or indirectly, the ordering of title insurance and related services:

1. Any owner or prospective owner of real or personal property or any interest therein;

2. Any lender or prospective lender in a transaction involving an obligation secured or to be secured either in whole or in part by real or personal property or any interest therein; and

3. Any agent, representative, attorney or employee of any owner or prospective owner or of any lender or prospective lender.

4. An affiliate producer.

(cm) "Supplementary rate information" has the meaning provided under s. 625.02 (3), Stats.

(d) "Title insurance rates" means all charges made by a title insurer in connection with the issuance of a title insurance policy or a commitment to issue a title insurance policy and includes, but is not limited to, search and examination charges.

(e) "Title insurer" means all insurance companies authorized to write title insurance as defined by s. Ins 6.75 (2) (h) and their affiliates, and includes all officers, employees and representatives of the insurance companies or their affiliates.

(4) PROHIBITED PRACTICES. No title insurer or agent of a title insurer may engage in any of the following practices:

(a) Charging an amount for a title insurance policy or commitment for a title insurance policy other than the amount developed by application of the appropriate title insurance rate developed from the rates and supplementary rate information on file with the commissioner for use by the title insurer.

(b) Waiving, or offering to waive, all or any part of the applicable title insurance rate or premium developed by proper application of the appropriate title insurance rate developed from the rates and supplementary rate information on file with the commissioner.

(c) Charging a reduced title insurance rate under a so−called "take−off"or subdivision policy when the property involved is ineligible for such reduced rate.

(d) Charging a reduced title insurance rate under a so−called "take−off"or subdivision policy when such rate is not applicable in the particular transaction because the volume required to qualify for such reduced rate includes ineligible property.

(e) Paying or offering to pay the cancellation fee, the fee for a preliminary title report or other fee on behalf of any producer of title insurance after inducing the person to cancel an order with another title insurer.

(f) Making or guaranteeing, or offering to make or guarantee, directly or indirectly, any loan to any producer of title insurance regardless of the terms of the note or guarantee. This prohibition is not applicable to customary business collection procedures, claims settlement and salvage activities and other business activities totally unrelated to the solicitation of business for which a charge is made.

(g) Providing or offering to provide, directly or indirectly, a"compensating balance" or deposit in a lending institution either for the express or implied purpose of influencing the extension of credit by the lending institution to any producer of title insurance, or for the express or implied purpose of influencing the placement or channeling of title insurance business by the lending institution. This paragraph does not prohibit the maintenance by a title insurer or agent of demand deposits or escrow deposits which are reasonably necessary for use in the ordinary course of the business of the title insurer or agent.

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(h) Paying or offering to pay the fees or charges of an outside professional, including but not limited to, an attorney, engineer, appraiser, or surveyor, whose services are required by any producer of title insurance to structure or complete a particular transaction.

(i) Paying or offering to pay all or part of the salary of an employee of a producer of title insurance.

(j) Paying or offering to pay a fee to a producer of title insurance for services unless the fee bears a reasonable relation to the services performed. The determination of whether a fee bears a reasonable relation to the services performed means a recognition of time and effort spent, risk and expenses incurred, and an allowance for a reasonable level of profit. After June 30, 1987, for purposes of this paragraph, a payment determined by applying a percentage amount or formula to the premium paid for title insurance is presumed, unless rebutted, not to bear a reasonable relation to services performed. The presumption may be rebutted in a particular case by satisfying the commissioner that the service to be performed and the compensation to be received, with recognition of time and effort spent and risk and expenses incurred, are substantially comparable to the services performed and compensation received by agents, or to the services performed by underwriters, in this state who are not producers of title insurance.

(k) Paying or offering to pay for services by a producer of title insurance if the services are required to be performed by the person in his or her capacity as a real estate or mortgage broker or salesperson or agent.

(L) Furnishing or offering to furnish, or paying or offering to pay for, furniture, office supplies, telephones, equipment or automobiles to a producer of title insurance, or paying for, or offering to pay for, any portion of the cost of renting, leasing, operating or maintaining any of these items. Marketing and title insurance promotional items clearly of an advertising nature of token or nominal value, or supplies such as title insurance application blanks and related forms are prohibited under this paragraph if they are made available to all producers of title insurance on the same terms and conditions.

(m) Paying for, furnishing, or waiving, or offering to pay for, furnish, or waive, all or any part of the rent for space occupied by a producer of title insurance.

(n) Renting or offering to rent space from a producer of title insurance, at a rent which is excessive when compared with rents for comparable space in the geographic area, or paying or offering to pay, rent based in whole or in part on the volume of business generated by a producer of title insurance except for a bona fide percentage lease based on the total volume of receipts of the title insurer when the services of that title insurer are offered from that location to the public generally.

(o) Paying or offering to pay for gifts, vacations, business trips, convention expenses, travel expenses, membership fees, registration fees, lodging or meals on behalf of a producer of title insurance, directly or indirectly, or supplying letters of credit, credit cards or any such benefits. This paragraph does not preclude reasonable, moderate and customary business entertainment and trade association activities and expense incurred and recorded by the title insurer or agent in the course of marketing its products and services.

(p) Paying or offering to pay money, prizes or other things of value to, or on behalf of, a producer of title insurance in a contest or promotional endeavor. This paragraph does not apply to offers or payments to trade associations or charitable or other functions where the thing of value is a contribution or donation rather than a business solicitation.

(q) Paying or offering to pay for advertising concerning the title insurer or agent in material distributed or promoted by a producer of title insurance, unless the payment is reasonable compensation for the advertising, is not greater than the amount charged for comparable advertising and any title insurer is permitted to advertise in the material on the same terms and conditions.

(r) Paying for or furnishing, or offering to pay for or furnish any brochures, billboards, or advertisements of a producer of title insurance, products or services appearing in newspapers, on the radio, or on television, or other advertising or promotional material published or distributed by, or on behalf of, a producer of title insurance.

(5) REFERRAL OF TITLE INSURANCE APPLICATIONS. For the purpose of sub. (3) (b), an application or order for title insurance is presumed to be referred to an agent by an affiliate producer of title insurance if the affiliated producer of title insurance acts as a broker, agent, lender, representative or attorney in the transaction which results in the application or order and the application was not referred to the affiliate producer by an unaffiliated producer of title insurance.

History: Cr. Register, December, 1975, No. 240, eff. 1−1−76; emerg. am. (1), (2) and (3) (a), eff. 6−22−76; am. (1) (2), (3) (a) and (4) (o), Register, September, 1976, No. 249, eff. 10−1−76; am. (2) and (3) (a), Register, March, 1979, No. 279, eff. 4−1−79; am. (2), (3) (c) (intro.), (d), (4) (intro.), (e) to (p) and (r), renum. (3) (a) and (e) to be (3) (e) and (cm) and am., cr. (3) (intro.), (a), (am), (bm) and (c) 4., r. and recr. (3) (b), (4) (q) and (5), Register, November, 1986, No. 371, eff. 12−1−86; emerg. am. (4) (j), eff. 7−5−88; am. (4) (j), Register, October, 1988, No. 396, eff. 1−1−89; correction in (5) made under s. 13.93 (2m) (b) 7., Stats., Register December 2002 No. 564.

Ins 3.34 Coverage of dependent. (1) PURPOSE. This section implements s. 632.885, Stats.

(2) APPLICABILITY. (a) This section applies to disability insurance policies as defined at s. 632.895 (1) (a), Stats., that are issued or renewed on or after January 1, 2010, including individual health and group health benefit plans. It applies to limited–scope plans including vision and dental plans but does not include hospital indemnity, income continuation, accident−only benefits, long−term care and Medigap policies. This section also applies to self−insured health plans as defined at s. 632.745 (24), Stats.

(b) For a disability insurance policy covering employees who are affected by a collective bargaining agreement this coverage under this section first applies as follows:

1. If the collective bargaining agreement contains provisions consistent with this law or that are silent on dependent eligibility, coverage under this section first applies the earliest of any of the following; the date the disability insurance policy is issued or renewed on or after January 1, 2010, or the date the self−insured health plan is established, modified, extended or renewed on or after January 1, 2010.

2. If the collective bargaining agreement contains provisions inconsistent with this law, the coverage under this section first applies on the date the health policy is first issued or renewed or a self−insured health plan is first established, modified, extended, or renewed on or after the earlier of the date the collectively bargained agreement expires, or the date the collectively bargained agreement it is modified, extended or renewed.

(3) DEFINITIONS. In this section and for purposes of applying s. 632.885, Stats.:

(a) "Adult child" means a child of the applicant, enrollee or insured who meets the eligibility requirements of s. 632.885 (2), Stats., as applicable.

(b) "Premium contribution" means the amount the adult child is required to pay for coverage under the adult child's employer−sponsored group health benefit plan or self−insured health plan.

(c) "Premium amount" means the additional amount the applicant or insured is required to pay for inclusion of the adult child under the applicant's or insured's health insurance policy or self−insured plan.

(4) PREMIUM DETERMINATION. To determine whether an adult child meets the eligibility standard in s. 632.885 (2) (a) 3., Stats., the insurer or self−insured health plan must use only the following:

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(a) The amount of the adult child's premium contribution.

(b) The amount of the applicant's or insured's premium amount.

(5) OFFER OF COVERAGE. (a) On or after January 1, 2010, an insurer and self−insured health plan shall offer coverage to an adult child of an applicant or insured as a new entrant when the applicant or insured requests enrollment of the adult child no later than 30 days after the date the adult child first becomes eligible according to this section. It is solely the applicant's or insured's decision whether or not to add eligible adult children to the plan to the extent permitted by law.

(b) Insurers and self−insured health plans may not limit or otherwise restrict the offer of coverage to an eligible adult child by requiring any of the following:

1. The eligible adult child to have been previously covered as a dependent.

2. The eligible adult child to reside in this state.

3. The eligible adult child to demonstrate that he or she had previous creditable coverage.

4. The insured or applicant to have requested coverage for an eligible adult child the first time the child was eligible for coverage.

(c) Insurers offering individual disability insurance may individually rate the eligible adult child and apply preexisting condition waiting periods consistent with s. 632.76 (2) (ac) 2., Stats., and may apply elimination riders to the eligible adult child, but may not do either of the following:

1. Deny coverage to an eligible adult child when the applicant or insured requests coverage.

2. Otherwise limit coverage if such limitation results in coverage that is illusory.

(d) Insurers offering group disability insurance policies and self−insured health plans shall comply with all of the following:

1. May not deny coverage of an eligible adult child when coverage is requested by the applicant or insured.

2. Shall apply portability rights to an eligible adult child so long as the adult child has not had a break in creditable coverage longer than 62 days.

3. Shall comply with s. 632.746, Stats., as applicable.

4. May request documentation of the adult child's creditable coverage for determining portability. The pre−existing condition waiting period applicable to the eligible adult child shall be applied to the adult child in the same manner as applied to any other applicant or eligible dependent.

(6) ELIGIBLE ADULT CHILD. (a) For purposes of this section and implementation of s. 632.885 (2), Stats., an adult child is eligible for coverage as a dependent if either of the following is met:

1. For an adult child who has not been called to federal active duty in the national guard or in a reserve component of the U.S. armed forces, either of the following:

a. An adult child who meets s. 632.885 (2) (a) 1., 2. and 3., Stats.

b. An adult child who meets s. 632.885 (2) (a) 1. and 2., Stats., and who is not eligible for his or her employer sponsored coverage or whose employer does not offer health insurance to its employees is an eligible adult child.

2. For an adult child who has been called to federal active duty in the national guard or in a reserve component of the U.S. armed forces and who meet s. 632.885 (2) (b) 1., 2., 3., and 4., Stats., all of the following:

a. The adult child must apply to an institution of higher education as a full−time student within 12 months from the date the adult child has fulfilled his or her active duty obligation.

b. When an adult child is called to active duty more than once within a four−year period of time, the insurer and self−insured health plan must use the adult child's age when first called to active duty for determining eligibility under this section.

History: EmR0930: emerg. cr. eff. 10−31−09; CR 09−076: cr. Register May 2010 No. 653, eff. 6−1−10; corrections in (title) and (6) (a) 1. b. made under s. 13.92 (4) (b) 2. and 7., Stats., Register May 2010 No. 653.

Ins 3.36 Coverage of autism spectrum disorders. **(1)** APPLICABILITY. (a) This section applies to disability insurance policies as defined in s. 632.895 (1) (a), Stats., except as provided in s. 632.895 (12m) (e), Stats., and self−insured health plans sponsored by the state, county, city, town, village, or school district.

(b) For a disability insurance policy covering employees who are affected by a collective bargaining agreement the coverage under this section first applies as follows:

1. If the collective bargaining agreement contains provisions consistent with s. 632.895 (12m), Stats., coverage under this section first applies the earliest of any of the following: the date the disability insurance policy is issued or renewed on or after November 1, 2009, or the date the self−insured health plan is established, modified, extended or renewed on or after November 1, 2009.

2. If the collective bargaining agreement contains provisions inconsistent with s. 632.895 (12m), Stats., the coverage under this section first applies on the date the health benefit plan is first issued or renewed or a self−insured health plan is first established, modified, extended, or renewed on or after the earlier of the date the collectively bargained agreement expires, or the date the collectively bargained agreement is modified, extended or renewed.

(2) DEFINITIONS. In addition to the definitions in s. 632.895 (12m) (a), Stats., in this section:

(a) "Behavior analyst" means a person certified by the Behavior Analyst Certification Board, Inc., or successor organization as a board−certified behavior analyst and has been granted a license under s. 440.312, Stats., to engage in the practice of behavior analysis.

(b) "Behavioral" means interactive therapies that target observable behaviors to build needed skills and to reduce problem behaviors using well−established principles of learning utilized to change socially important behaviors with the goal of building a range of communication, social and learning skills, as well as reducing challenging behaviors.

(c) "Department" means the Wisconsin department of health services.

(d) "Efficacious treatment" or "efficacious strategy" means treatment or strategies designed to address cognitive, social or behavioral conditions associated with autism spectrum disorders; to sustain and maximize gains made during intensive−level services; or to improve an individual with autism spectrum disorder's condition.

(e) "Evidence−based therapy" means therapy, service and treatment that is based upon medical and scientific evidence as described at s. 632.835 (3m) (b) 1., 2. (intro.) and a., Stats., and s. Ins 18.10 (4), is determined to be an efficacious treatment or strategy and is prescribed to improve the insured's condition or to achieve social, cognitive, communicative, self−care or behavioral goals that are clearly defined within the insured's treatment plan.

(f) "Intensive−level service" means evidence−based behavioral therapies that are directly based on, and related to, an insured's therapeutic goals and skills as prescribed by a physician familiar with the insured. Intensive−level service may include evidence−based speech therapy and occupational therapy provided by a qualified therapist when such therapy is based on, or related to, an insured's therapeutic goals and skills, and is concomitant with evidence−based behavioral therapy.

(g) "Qualified intensive−level professional" means an individual working under the supervision of an outpatient mental health clinic who is a licensed treatment professional as defined in s.

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DHS 35.03 (9g), and who has completed at least 2080 hours of training, education and experience including all of the following:

1. Fifteen hundred hours supervised training involving direct one−on−one work with individuals with autism spectrum disorders using evidence−based, efficacious therapy models.

2. Supervised experience with all of the following:

a. Working with families as part of a treatment team and ensuring treatment compliance.

b. Treating individuals with autism spectrum disorders who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths.

c. Treating individuals with autism spectrum disorders with a variety of behavioral challenges.

d. Treating individuals with autism spectrum disorders who have shown improvement to the average range in cognitive functioning, language ability, adaptive and social interaction skills.

e. Designing and implementing progressive treatment programs for individuals with autism spectrum disorders.

3. Academic coursework from a regionally−accredited higher education institution with demonstrated coursework in the application of evidence−based therapy models consistent with best practice and research on effectiveness for individuals with autism spectrum disorders.

(h) "Qualified intensive−level provider" means an individual identified in s. 632.895 (12m) (b) 1. to 4., Stats., acting within the scope of a currently valid state−issued license for psychiatry, psychology or behavior analyst, or a social worker acting within the scope of a currently valid state−issued certificate or license to practice psychotherapy, who provides evidence−based behavioral therapy in accordance with this section and s. 632.895 (12m) (a) 3., Stats., and who has completed at least 2080 hours of training, education and experience which includes all of the following:

1. Fifteen hundred hours supervised training involving direct one−on−one work with individuals with autism spectrum disorders using evidence−based, efficacious therapy models.

2. Supervised experience with all of the following:

a. Working with families as the primary provider and ensuring treatment compliance.

b. Treating individuals with autism spectrum disorders who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths.

c. Treating individuals with autism spectrum disorders with a variety of behavioral challenges.

d. Treating individuals with autism spectrum disorders who have shown improvement to the average range in cognitive functioning, language ability, adaptive and social interaction skills.

e. Designing and implementing progressive treatment programs for individuals with autism spectrum disorders.

3. Academic coursework from a regionally−accredited higher education institution with demonstrated coursework in the application of evidence−based therapy models consistent with best practice and research on effectiveness for individuals with autism spectrum disorders.

(i) "Qualified paraprofessional" means an individual working under the active supervision of a qualified supervising provider, qualified intensive−level provider or qualified provider and who complies with all of the following:

1. Is at least 18 years of age.

2. Obtains a high school diploma.

3. Completes a criminal background check.

4. Obtains at least 20 hours of training that includes subjects related to autism, evidence−based treatment methods, communication, teaching techniques, problem behavior issues, ethics, special topics, natural environment, and first aid.

5. Obtains at least ten hours of training in the use of behavioral evidence−based therapy including the direct application of training techniques with an individual who has autism spectrum disorder present.

6. Receives regular, scheduled oversight by a qualified supervising provider in implementing the treatment plan for the insured.

(j) "Qualified professional" means an individual identified in s. 632.895 (12m) (b) 5., Stats., acting under the supervision of an outpatient mental health clinic certified under s. 51.038, Stats., acting within the scope of a currently valid state−issued license and who provides evidence−based therapy in accordance with this section.

(k) "Qualified provider" means an individual identified in s. 632.895 (12m) (b) 1. to 4., Stats., respectively, acting within the scope of a currently valid state−issued license for psychiatry, psychology or behavior analyst, or a social worker acting within the scope of a currently valid state−issued certificate or license to practice psychotherapy and who provides evidence−based therapy in accordance with this section.

(L) "Qualified supervising provider" means an individual who is a qualified intensive−level provider and who has completed at least 4160 hours of experience as a supervisor of less experienced providers, professionals and paraprofessionals.

(m) "Qualified therapist" means an individual identified in s. 632.895 (12m) (b) 6. or 7., Stats., who is either a speech−language pathologist or occupational therapist acting within the scope of a currently valid state−issued license and who provides evidence−based therapy in accordance with this section, sub. (4) (e).

(n) "Supervision of an outpatient mental health clinic" for purposes of this section means an individual who meets the requirements of a qualified supervising provider and who periodically reviews all treatment plans developed by qualified professionals for insureds with autism spectrum disorders.

(o) "Waiver program" means services provided by the department through the Medicaid Home and Community−Based Services as granted by the Centers for Medicare & Medicaid Services.

(3) VERIFIED DIAGNOSIS. (a) Insurers and self−insured health plans shall provide coverage for services to an insured who has a primary verified diagnosis of autism spectrum disorder made by a diagnostician skilled in testing and in the use of empirically−validated tools specific for autism spectrum disorders.

(b) Insurers and self−insured health plans shall accept as valid and provide coverage for the diagnostic testing in addition to the benefit mandated by s. 632.895 (12m), Stats. For the diagnosis to be valid for autism spectrum disorder, the testing tools shall be appropriate to the presenting characteristics and age of the insured and be empirically validated for autism spectrum disorders to provide evidence that the insured meets the criteria for autism spectrum disorder in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Insurers and self−insured health plans may require confirmation of a primary diagnosis through completion of empirically−validated tools or tests from each of the following categories: intelligence, parent report, language skills, adaptive behavior, and direct observation of the child.

(c) An insurer and a self−insured health plan may require an insured to obtain a second opinion from a diagnostician experienced in the use of empirically−validated tools specific for autism spectrum disorders who is mutually agreeable to the insured or the insured's parent or authorized representative and to the insurer or self−insured health plan. An insurer and a self−insured health plan shall cover the cost of the second opinion and the cost of the second opinion shall be in addition to the benefit mandated by s. 632.895 (12m), Stats.

(d) Insurers and self−insured health plans may require that the assessment include both a standardized parent interview regarding current concerns and behavioral history as well as direct, structured observation of social and communicative behavior and

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play. The diagnostic evaluation shall also assess those factors that are not specific to autism spectrum disorders including degree of language impairment, cognitive functioning, and the presence of nonspecific behavioral disorders.

(4) INTENSIVE–LEVEL SERVICES. (a) *Coverage for intensive–level services*. Insurers and self–insured health plans shall provide coverage for evidence–based behavioral intensive–level therapy for an insured with a verified diagnosis of autism spectrum disorder, the majority of which shall be provided to the insured when the parent or legal guardian is present and engaged and all of the prescribed therapy is consistent with all of the following requirements:

1. Based upon a treatment plan developed by an individual who at least meets the requirements of a qualified intensive–level provider or a qualified intensive–level professional that includes at least 20 hours per week over a six–month period of time of evidence–based behavioral intensive therapy, treatment, and services with specific cognitive, social, communicative, self–care, or behavioral goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the insured be present and engaged in the intervention.

2. Implemented by qualified providers, qualified professionals or qualified therapists, or qualified paraprofessionals.

3. Provided in an environment most conducive to achieving the goals of the insured's treatment plan.

4. Implemented identified therapeutic goals developed by the team including training and consultation, participation in team meetings and active involvement of the insured's family.

5. Commenced after an insured is two years of age and before the insured is nine years of age.

6. Provided by a qualified intensive–level provider or qualified intensive–level professional who directly observes the insured at least once every two months.

(b) *Forty–eight cumulative months*. Insurers and self–insured health plans shall provide up to forty–eight months of intensive–level services. Insurers and self–insured health plans may credit against the required forty–eight months of intensive–level services any previous intensive–level services the insured received regardless of payor. Insurers and self–insured health plans may require documentation including medical records and treatment plans to verify any evidence–based behavioral therapy the insured received for autism spectrum disorders that was provided to the insured prior to the insured attaining nine years of age. Insurers and self–insured health plans may consider any evidence–based behavioral therapy that was provided to the insured for an average of 20 or more hours per week over a continuous six–month period to be intensive–level services.

(c) *Travel*. Insurers and self–insured health plans shall not include coverage of travel time for qualified providers, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals when calculating the number of hours of care provided per week and are not required to separately reimburse for travel time.

(d) *Progress assessment*. Insurers and self–insured health plans shall require that progress be assessed and documented throughout the course of treatment. Insurers and self–insured health plans may request and review the insured's treatment plan and the summary of progress on a periodic basis.

(e) *Concomitant therapy*. Insurers and self–insured health plans shall provide coverage pursuant to s. 632.895 (12m) (c), Stats., for a qualified therapist when services are rendered concomitant with intensive–level evidence–based behavioral therapy and all of the following:

1. The qualified therapist provides evidence–based therapy to an insured who has a primary diagnosis of an autism spectrum disorder.

2. The insured is actively receiving behavioral services from a qualified intensive–level provider or qualified intensive–level professional.

3. The qualified therapist develops and implements a treatment plan consistent with their license and this section.

(5) NONINTENSIVE–LEVEL SERVICES. (a) *Coverage for nonintensive–level services*. Insurers and self–insured health plans shall provide coverage for an insured with a verified diagnosis of autism spectrum disorder for nonintensive–level services that are evidence–based and that are provided to an insured by a person who is at least a qualified provider, a qualified professional, a qualified therapist or a qualified paraprofessional in either of the following conditions:

1. After the completion of intensive–level services and designed to sustain and maximize gains made during intensive–level services treatment.

2. To an insured who has not and will not receive intensive–level services but for whom nonintensive–level services will improve the insured's condition.

(b) *Requirements for coverage*. Insurers and self–insured health plans shall provide coverage for evidence–based therapy that is consistent with all of the following requirements:

1. Based upon a treatment plan developed by an individual who minimally meets the requirements as a qualified provider, a qualified professional or a qualified therapist that includes specific evidence–based therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the insured be present and engaged in the intervention.

2. Implemented by a person who is at least a qualified provider, qualified professional, qualified therapist, or a qualified paraprofessional.

3. Provided in an environment most conducive to achieving the goals of the insured's treatment plan.

4. Implements identified therapeutic goals developed by the team including training and consultation, participation in team meetings and active involvement of the insured's family.

(c) *Services*. Insurers and self–insured health plans shall provide coverage for nonintensive–level services that may include direct or consultative services when provided by qualified providers, qualified supervising providers, qualified professionals, qualified therapists, or qualified paraprofessionals.

(d) *Progress assessment*. Insurers and self–insured health plans shall require that progress be assessed and documented throughout the course of treatment. Insurers and self–insured health plans may request and review the insured's treatment plan and the summary of progress on a periodic basis.

(e) *Travel*. Insurers and self–insured health plans shall not include coverage of travel time by qualified providers, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals when calculating the number of hours of care provided per week and are not required to separately reimburse for travel time.

(6) TRANSITION TO NONINTENSIVE–LEVEL SERVICES. (a) *Notice of transition by insurer*. Insurers and self–insured plans shall provide notice to the insured or the insured's authorized representative regarding change in an insured's level of treatment. The notice shall indicate the reason for transition that may include any of the following:

1. The insured has received forty–eight cumulative months of intensive–level services.

2. The insured no longer requires intensive–level services as supported by documentation from a qualified supervising provider, qualified intensive–level provider, or a qualified intensive–level professional.

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3. The insured no longer receives evidence−based behavioral therapy for at least 20 hours per week over a six−month period of time.

(b) *Notice of break in service by insured*. Insurers and self−insured plans may require an insured or an insured's authorized representative to promptly notify the insurer or self−insured plan if the insured requires and qualifies for intensive−level services but the insured or the insured's family or caregiver is unable to receive intensive−level services for an extended period of time. The insured or the insured's authorized representative shall indicate the specific reason or reasons the insured or the insured's family or caregiver is unable to comply with an intensive−level service treatment plan. Reasons for requesting intensive−level services be interrupted for an extended period of time may include a significant medical condition, surgical intervention and recovery, catastrophic event or any other reason the insurer or self−insured plan determines to be acceptable.

(c) *Documentation*. Insurers and self−insured plans may not deny intensive−level services to an insured for failing to maintain at least 20 hours per week of evidence−based behavioral therapy over a six−month period when the insured or the insured's authorized representative complied with par. (b) or the insured or the insured's authorized representative can document that the insured failed to maintain at least 20 hours per week of evidence−based behavioral therapy due to waiting for waiver program services.

(7) NOTICE TO INSUREDS. Insurers and self−insured plans shall provide written notice regarding claims submitted and processed for the treatment of autism spectrum disorders to the insured or insured's parents or authorized representative and include the total amount expended to date for the current policy year. The notice may be included with the explanation of benefits form or in a separate communication provided on a periodic basis during the course of treatment.

(8) RESEARCH THAT IS THE BASIS FOR EFFICACIOUS TREATMENT OR EFFICACIOUS STRATEGIES. Research designs that are sufficient to demonstrate that a treatment or strategy when used solely or in combination with other treatments or strategies, is effective in addressing the cognitive, social, and behavioral challenges associated with autism spectrum disorders demonstrates significant improvement shall include at least one of the following:

(a) Two or more high quality experimental or quasi−experimental group design studies that meet all of the following criteria:

1. A clearly defined population for whom inclusion criteria have been delineated in a reliable, valid manner.

2. Outcome measures with established reliability and construct validity.

3. Independent evaluators who are not aware of the particular treatment utilized.

(b) Five or more single subject design studies that meet all of the following criteria:

1. Studies must have been published in a peer−reviewed scientific or medical journal.

2. Studies must have been conducted by three different researchers or research groups in three different geographical locations.

3. The body of studies must have included 20 or more participants.

(c) One high quality randomized or quasi−experimental group design study that meets all of the criteria in par. (a) and three high−quality single−subject design studies that meet all of the criteria in par. (b).

(9) DISPUTES. An insurer's or a self−insured health plan's determination regarding diagnosis and level of service may be considered an adverse determination if the insured disagrees with the determination. The insured or the insured's authorized representative may file a grievance in accordance with s. Ins 18.03. The insured or the insured's authorized representative may seek independent review of the coverage denial determination in accordance with s. Ins 18.11.

(10) NON−REQUIRED COVERAGE. (a) *Services*. Insurers and self−insured health plans are not required to cover any of the following:

1. Acupuncture.
2. Animal−based therapy including hippotherapy.
3. Auditory integration training.
4. Chelation therapy.
5. Child care fees.
6. Cranial sacral therapy.
7. Custodial or respite care.
8. Hyperbaric oxygen therapy.
9. Special diets or supplements.

(b) *Drugs and devices*. Insurers and self−insured health plans shall not provide coverage for pharmaceuticals or durable medical equipment through s. 632.895 (12m), Stats. Coverage of pharmaceuticals and durable medical equipment shall be covered in compliance with the terms of the insured's policy.

(c) *Fraudulent claims*. Insurers and self−insured health plans shall not be required to pay claims that have been determined to be fraudulent.

(d) *Parents of children diagnosed with autism spectrum disorders*. Insurers and self−insured health plans shall not be required to pay for treatment rendered by parents or legal guardians who are otherwise qualified providers, qualified supervising providers, qualified therapists, qualified professionals or qualified paraprofessionals for treatment rendered to their own children.

(e) *Denial of coverage*. If an insurer or self−funded health plan generally provides benefits for an illness or injury, the insurer or self−funded health plan may not deny benefits otherwise provided for treatment of that illness or injury solely because the illness or injury relates to the insured's autism spectrum disorder.

(11) LOCATIONS FOR SERVICES. (a) Insurers and self−insured health plans shall cover treatments, therapies and services to an insured diagnosed with autism spectrum disorders in locations including the provider's office, clinic or in a setting conducive to the acquisition of the target skill. Treatments may be provided in schools when they are related to the goals of the treatment plan and do not duplicate services provided by a school.

(b) Insurers and self−insured health plans are not required to cover therapy, treatment or services when provided to an insured who is residing in a residential treatment center, inpatient treatment or day treatment facility.

(c) Insurers and self−insured health plans are not required to cover the cost for the facility or location or for the use of a facility or location when treatment, services or evidence−based therapy are provided outside an insured's home.

(12) ANNUAL PUBLICATION CPI ADJUSTMENT. The commissioner shall publish to the office of the commissioner of insurance website on or before December 1 of each year beginning December 1, 2011, the consumer price index for urban consumers as determined by the U.S. Department of Labor and publish the adjusted dollar amount in accordance with s. 632.895 (12m) (c) 1., Stats. The adjusted dollar amount published each December shall be used by insurers and self−insured health plans when complying with s. 632.895 (12m), Stats., effective the following January 1 for newly issued policies or on the first date of a modified, extended or renewed policy or certificate after January 1.

(14) VERIFICATION OF SERVICE PROVIDERS. (a) Insurers and self−insured health plans are required to verify the licensure, certification and all training or other credentials of a qualified supervising or intensive−level provider, a qualified provider and a qualified therapist.

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(b) Insurers and self−insured health plans shall require the following:

1. All service providers employing qualified paraprofessionals to verify the qualified paraprofessional's credentials and to document that such employee or contractee has not been convicted of a felony or any crime involving maltreatment of a child in any jurisdiction and to periodically review and verify continuing compliance with this paragraph.

2. Certified outpatient mental health clinics employing or contracting for the services of qualified intensive−level professionals or qualified professionals to verify the credentials of a qualified intensive−level professional or qualified professional and to document that such employee or contractee has not been convicted of a felony or any crime involving maltreatment of a child in any jurisdiction and to periodically review and verify continuing compliance with this paragraph.

(c) A provider, therapist, or professional working under the supervision of a certified outpatient mental health clinic, who is approved by the department and who has a signed Medicaid provider agreement to provide services through the waiver program to individuals with autism spectrum disorders prior to November 1, 2009 shall be deemed to be a qualified intensive−level provider or qualified intensive−level professional through October 31, 2011. Beginning November 1, 2011 any provider, therapist or professional shall comply with the training and education requirements for a qualified supervising provider, qualified intensive−level provider, qualified provider, qualified intensive−level professional, qualified professional or qualified therapist.

(d) An insurer or self−insured health plans may elect to contract with certain providers, therapists and professionals who do not meet all of the requirements necessary to be considered qualified supervising providers, qualified intensive−level providers, qualified providers, qualified therapists, qualified intensive−level professionals or qualified professionals but who are approved by the department and who have a signed Medicaid provider agreement to provide services through the waiver program to individuals with autism spectrum disorders and who meet any criteria established by the insurer or self−insured health plan. The insurer or self−insured health plans shall have a verifiable and established process for rendering its determination for otherwise qualified supervising provider, qualified intensive−level provider, qualified provider, qualified intensive−level professional, qualified professional or qualified therapist.

History: EmR1005: emerg. cr. eff. 3−8−10; CR 10−043: cr. Register September 2010 No. 657, eff. 10−1−10.

Ins 3.37 Transitional treatment arrangements. (1) PURPOSE. This section implements s. 632.89 (4), Stats.

(2) APPLICABILITY. This section applies to group and blanket disability insurance policies issued or renewed on and after November 1, 1992, that provide coverage for inpatient hospital services or outpatient services, as defined in s. 632.89 (1) (d) or (e), Stats.

(3) COVERED SERVICES. A policy subject to this section shall provide at least the amount of coverage required under s. 632.89 (2) (dm) 2., Stats., subject to the exclusions or limitations, including deductibles and copayments, that are generally applicable to coverage required under s. 632.89 (2), Stats., for all of the following:

Note: Section 632.89 (2) (dm) 2., is repealed effective 12−1−10, by 2009 Wis. Act 218.

(a) Mental health services for adults in a day treatment program offered by a provider certified by the department of health services under s. DHS 61.75.

(b) Mental health services for children and adolescents in a day treatment program offered by a provider certified by the department of health services under s. DHS 40.04.

(c) Services for persons with chronic mental illness provided through a community support program certified by the department of health services under s. DHS 63.03.

(d) Residential treatment programs for alcohol or drug dependent persons, or both, certified by the department of health services under s. DHS 75.14 (1) and (2).

(e) Services for alcoholism and other drug problems provided in a day treatment program certified by the department of health services under s. DHS 75.12 (1) and (2).

(f) Intensive outpatient programs for the treatment of psychoactive substance use disorders provided in accordance with the patient placement criteria of the American society of addiction medicine.

(g) Coordinated emergency mental health services for persons who are experiencing a mental health crisis or who are in a situation likely to turn into a mental health crisis if support is not provided. Services are provided by a program certified by the department of health services under s. DHS 34.03 and provided in accordance with subch. III of ch. DHS 34 for the period of time the person is experiencing a mental health crisis until the person is stabilized or referred to other providers for stabilization. Certified emergency mental health service plans shall provide timely notice to third−party payors to facilitate coordination of services for persons who are experiencing or are in a situation likely to turn into a mental health crisis.

(4) OUT−OF−STATE SERVICES AND PROGRAMS. An insurer may comply with sub. (3) (a) to (e) by providing coverage for services and programs that are substantially similar to those specified in sub. (3) (a) to (e), if the provider is in compliance with similar requirements of the state in which the provider is located.

(5) POLICY FORM REQUIREMENTS. An insurer shall specify in each policy form all of the following:

(a) The types of transitional treatment programs and services covered by the policy as specified in sub. (3).

(b) The method the insurer uses to evaluate a transitional treatment program or service to determine if it is medically necessary and covered under the terms of the policy.

History: Emerg. cr. eff. 9−29−92; cr. Register, February, 1993, No. 446, eff. 3−1−93; corrections made under s. 13.93 (2m) (b) 6. and 7., Stats., Register, June, 1997, No. 498; correction in (3) (c) made under s. 13.93 (2m) (b) 7., Stats., Register, July, 2000, No. 535; CR 02−051: am. (3) (intro.), (b), (d) and (e), cr. (3) (g) Register December 2002 No. 564, eff. 1−1−03; corrections in (3) (a) to (e) and (g) made under s. 13.92 (4) (b) 6. and 7., Stats., Register October 2008 No. 634.

Ins 3.38 Coverage of newborn infants. (1) PURPOSE. This section is intended to interpret and implement s. 632.895 (5), Stats.

(2) INTERPRETATION AND IMPLEMENTATION. (a) Coverage of each newborn infant is required under a disability insurance policy if:

1. The policy provides coverage for another family member, in addition to the insured person, such as the insured's spouse or a child, and

2. The policy specifically indicates that children of the insured person are eligible for coverage under the policy.

(b) Coverage is required under any type of disability insurance policy as described in par. (a), including not only policies providing hospital, surgical or medical expense benefits, but also all other types of policies described in par. (a), including accident only and short term policies.

(c) The benefits to be provided are those provided by the policy and payable, under the stated conditions except for waiting periods, for children covered or eligible for coverage under the policy.

(d) Benefits are required from the moment of birth for covered occurrences, losses, services or expenses which result from an injury or sickness condition, including congenital defects and birth abnormalities of the newborn infant to the extent that such covered occurrences, losses, services or expenses would not have been necessary for the routine postnatal care of the newborn child in the absence of such injury or sickness. In addition, under a policy providing coverage for hospital confinement and/or in−hospital doctor's charges, hospital confinement from birth contin-

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uing beyond what would otherwise be required for a healthy baby (e.g. 5 days) as certified by the attending physician to be medically necessary will be considered as resulting from a sickness condition.

(e) If a disability insurance policy provides coverage for routine examinations and immunizations, such coverage is required for covered children from the moment of birth.

(f) An insurer may underwrite a newborn, applying the underwriting standards normally used with the disability insurance policy form involved, and charge a substandard premium, if necessary, based upon such underwriting standards and the substandard rating plan applicable to such policy form. The insurer shall not refuse initial coverage for the newborn if the applicable premium, if any, is paid as required by s. 632.895 (4) (c), Stats. Renewal coverage for a newborn shall not be refused except under a policy which permits individual termination of coverage and only as such policy's provisions permit.

(g) An insurer receiving an application, for a policy as described in par. (a) providing hospital and/or medical expense benefits, from a pregnant applicant or an applicant whose spouse is pregnant, may not issue such a policy to exclude or limit benefits for the expected child. Such a policy must be issued without such an exclusion or limitation, or the application must be declined or postponed.

(h) Coverage is not required for the child born, after termination of the mother's coverage, to a female insured under family coverage who is provided extended coverage for pregnancy expenses incurred in connection with the birth of such child.

(i) A disability insurance policy described in par. (a) shall contain the substance of s. 632.895 (5), Stats.

(j) Policies issued or renewed on or after November 8, 1975, and before May 5, 1976, shall be administered to comply with s. 204.325, Stats., contained in chapter 98, Laws of 1975. Policies issued or renewed on or after May 5, 1976, and before June 1, 1976, shall be administered to comply with s. 632.895 (5), Stats., contained in chapter 224, Laws of 1975. Policies issued or renewed on or after June 1, 1976, shall be amended to comply with the requirements of s. 632.895 (5), Stats.

History: Cr. Register, February, 1977, No. 254, eff. 3−1−77; reprinted, Register, April, 1977, No. 256, to restore dropped text; corrections in (1) (intro.), (i) and (j), made under s. 13.93 (2m) (b) 7., Stats., Register, April, 1992, No. 436; correction in (1) (f) made under s. 13.93 (2m) (b) 7., Stats., Register, June, 1994, No. 462.

Ins 3.39 Standards for disability insurance sold to the Medicare eligible. (1) PURPOSE. (a) This section establishes requirements for health and other disability insurance policies or certificates primarily sold to Medicare eligible persons. Disclosure provisions are required for other disability policies or certificates sold to Medicare eligible person because such policies or certificates frequently are represented to, and purchased by, the Medicare eligible as supplements to Medicare products, including Medicare Advantage and Medicare Prescription Drug plans.

(b) This section seeks to reduce abuses and confusion associated with the sale of disability insurance to Medicare eligible persons by providing reasonable standards. The disclosure requirements and established benefit standards are intended to provide to Medicare eligible persons guidelines that they can use to compare disability insurance policies and certificates and to aid them in the purchase of policies and certificates intended to supplement Medicare and Medicare Advantage plans that are suitable for their needs. This section is designed not only to improve the ability of the Medicare eligible consumer to make an informed choice when purchasing disability insurance, but also to assure the Medicare eligible persons of this state that the commissioner will not approve a policy or certificate as "Medicare supplement" or as a "Medicare replacement" unless it meets the requirements of this section.

(c) Any disability insurance policy or certificate that is designed to reduce or eliminate gaps arising from the coverages in a Medicare Advantage or Medicare Part D Prescription Drug plan shall comply with this section, and pursuant to s. 104 (c) of Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (42 U.S.C. 1302, 1395w−101 et. seq.), policies and certificates that are advertised, marketed or designed primarily to cover out−of−pocket costs under Medicare Advantage plans shall comply with Medicare supplement requirements of s. 1882 (o) the federal Social Security Act (42 U.S.C. Section 1395 et. seq.).

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

(2) SCOPE. This section applies to individual and group disability policies sold, delivered or issued for delivery in Wisconsin to Medicare eligible persons as follows:

(a) Except as provided in pars. (d) and (e), this section applies to any group or individual Medicare supplement policy as defined in s. 600.03 (28r), Stats., or any Medicare replacement policy as defined in s. 600.03 (28p) (a) and (c), Stats., including:

1. Any Medicare supplement policy or Medicare replacement policy issued by a voluntary sickness care plan subject to ch. 185, Stats.;

2. Any certificate issued under a group Medicare supplement policy or group Medicare replacement policy;

3. Any individual or group policy sold in Wisconsin predominantly to individuals or groups of individuals who are 65 years of age or older which offers hospital, medical, surgical, or other disability coverage, except for a policy which offers solely nursing home, hospital confinement indemnity, or specified disease coverage; and

4. Any conversion contract offered to a Medicare eligible person, if the prior individual or group policy includes no provision inconsistent with the requirements of this section.

5. Any individual or group policy or certificate sold in Wisconsin to persons under 65 years of age and eligible for medicare by reason of disability which offers hospital, medical, surgical or other disability coverage, except for a policy or certificate which offers solely nursing home, hospital confinement indemnity or specified disease coverage.

(b) Except as provided in pars. (d) and (e), subs. (9) and (11) apply to any individual disability policy sold to a person eligible for Medicare which is not a Medicare supplement or a Medicare replacement policy as described in par. (a).

(c) Except as provided in par. (e), sub. (10) applies to:

1. Any conversion policy which is offered to a person eligible for Medicare as a replacement for prior individual or group hospital or medical coverage, other than a Medicare supplement or a Medicare replacement policy described in par. (a); and

2. Any individual or group hospital or medical policy which continues with changed benefits after the insured becomes eligible for Medicare.

(d) Except as provided in subs. (10) and (13), this section does not apply to:

1. A group policy issued to one or more employers or labor organizations, to the trustees of a fund established by one or more employers or labor organizations, or a combination of both, for employees or former employees or both, or for members or former members or both of the labor organizations;

3. Individual or group hospital, surgical, medical, major medical, or comprehensive medical expense coverage which continues after an insured becomes eligible for Medicare; or

4. A conversion contract offered to a Medicare eligible person as a replacement for prior individual or group hospital, surgical, medical, major medical, or comprehensive medical expense coverage, if the prior policy includes provisions which are inconsistent with the requirements of this section.

(e) This section does not apply to:

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1. A policy providing solely accident, dental, vision, disability income, or credit disability income coverage; or

2. A single premium, non−renewable policy.

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

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

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

1. The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided" means accidental bodily injury sustained by the insured person that is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

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

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

(c) "Applicant" means:

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

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

(ce) "Balance bill" means seeking: to bill, charge, or collect a deposit, remuneration or compensation from; to file or threaten to file with a credit reporting agency; or to have any recourse against an enrollee or any person acting on the enrollee's behalf for health care costs for which the enrollee is not liable. The prohibition on recovery does not affect the liability of an enrollee for any deductibles, coinsurance or copayments, or for premiums owed under the policy or certificate.

(cs) "Bankruptcy" means when a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

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

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

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

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

(h) "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than 63 days.

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

a. A group health plan;

b. Health insurance coverage;

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

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

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

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

g. A state health benefits risk pool;

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

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

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

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

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

b. Coverage issued as a supplement to liability insurance;

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

d. Worker's compensation or similar insurance;

e. Automobile medical payment insurance;

f. Credit−only insurance;

g. Coverage for on−site medical clinics; and

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

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

a. Limited scope dental or vision benefits;

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

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

4. "Creditable coverage" shall not include the following benefits if offered as independent, non−coordinated benefits:

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

b. Hospital indemnity or other fixed indemnity insurance.

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

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

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

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

(j) "Employee welfare benefit plan" means a plan, fund or program of employee benefits as defined in 29 USC 1002 (Employee Retirement Income Security Act).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) MEDICARE SUPPLEMENT AND MEDICARE REPLACEMENT POLICY AND CERTIFICATE REQUIREMENTS FOR POLICIES AND CERTIFICATES EFFECTIVE DATES PRIOR TO JUNE 1, 2010. Except as explicitly allowed by subs. (5), (7) and (30), no disability insurance policy or certificate shall relate its coverage to Medicare or be structured, advertised, solicited, delivered or issued for delivery in this state after December 31, 1990 for policies or certificates with effective dates prior to June 1, 2010, as a Medicare supplement policy or certificate or as a Medicare replacement policy or certificate, as defined in s. 600.03 (28p) (a) and (c), Stats., unless it complies with the following:

(a) The policy or certificate:

1. Provides only the coverage set out in sub. (5), (7) or (30) and applicable statutes and contains no exclusions or limitations other than those permitted by sub. (8). No issuer may issue a Medicare cost or Medicare select policy without prior approval from the commissioner and compliance with subs. (7) and (30), respectively.

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

3. Contains no definitions of terms such as "Medicare eligible expenses," "accident," "sickness," "mental or nervous disorders," skilled nursing facility," "hospital," "nurse," "physician," "Medicare approved expenses," "benefit period," "convalescent nursing home," or "outpatient prescription drugs" that are worded less favorably to the insured person than the corresponding Medicare definition or the definitions contained in sub. (3), and defines "Medicare" as in accordance with sub. (3) (q).

4. Does not indemnify against losses resulting from sickness on a different basis from losses resulting from accident;

5. Is "guaranteed renewable" and does not provide for termination of coverage of a spouse solely because of an event specified for termination of coverage of the insured, other than the nonpayment of premium. The policy shall not be cancelled or nonrenewed by the insurer on the grounds of deterioration of health. The policy may be cancelled only for nonpayment of premium or material misrepresentation. If the policy is issued by a health maintenance organization as defined by s. 609.01 (2), Stats., the policy may, in addition to the above reasons, be cancelled or nonrenewed by the issuer if the insured moves out of the service area;

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

7. Contains statements on the first page and elsewhere in the policy which satisfy the requirements of s. Ins 3.13 (2) (c), (d) or (e), and clearly states on the first page or schedule page the duration of the term of coverage for which the policy or certificate is issued and for which it may be renewed (the renewal period can-

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not be less than the greater of 3 months, the period for which the insured has paid the premium or the period specified in the policy);

8. Changes benefits automatically to coincide with any changes in the applicable Medicare deductible amount, coinsurance, and copayment percentage factors, although there may be a corresponding modification of premiums in accordance with the policy or certificate provisions and ch. 625, Stats.

9. Prominently discloses any limitations on the choice of providers or geographical area of service;

10. Contains on the first page the designation, printed in 18−point type, and in close conjunction the caption printed in 12−point type, prescribed in sub. (5), (7) or (30);

11. Contains text which is plainly printed in black or blue ink the size of which is uniform and not less than 10−point with a lower−case unspaced alphabet length not less than 120−point;

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

13. Is approved by the commissioner.

14. Contains no exclusion, limitation, or reduction of coverage for a specifically named or described condition after the policy effective date.

15. Provides for midterm cancellation at the request of the insured and that, if an insured cancels a policy midterm or the policy terminates midterm because of the insured's death, the issuer shall issue a pro rata refund to the insured or the insured's estate.

16. Except for permitted preexisting condition clauses as described in subd. 2., no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

17. No Medicare supplement policy or certificate in force in this state shall contain benefits that duplicate benefits provided by Medicare.

18. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period not to exceed 24 months in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to the assistance.

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

18p. Each Medicare supplement policy shall provide, and contain within the policy, that benefits and premiums under the policy shall be suspended for any period that may be provided by federal regulation, at the request of the policyholder if the policyholder is entitled to benefits under section 226 (b) of the Social Security Act and is covered under a group health plan, as defined in section 1862 (b)(1)(A)(v)of the Social Security Act. If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted, effective as of the date of loss of coverage, if the policyholder provides notice of loss of coverage within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

18r. Reinstitution of such coverages:

a. Shall not provide for any waiting period with respect to treatment of preexisting conditions;

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

c. Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

19. Shall not use an underwriting standard for under age 65 that is more restrictive than that used for age 65 and above.

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

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

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

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

(b) The outline of coverage for the policy or certificate.

1. Is provided to all applicants at the time application is made and, except in the case of direct response insurance, the issuer obtains written acknowledgement from the applicant that the outline was received;

2. Complies with s. Ins 3.27, including s. Ins 3.27 (5) (L) and (9) (u), (v) and (zh) 2. and 4.

3. Is substituted to properly describe the policy or certificate as issued, if the outline provided at the time of application did not properly describe the coverage which was issued. The substituted outline shall accompany the policy or certificate when it is delivered and shall contain the following statement in no less than 12−point type and immediately above the company name: "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application, and the coverage originally applied for has not been issued.";

4. Contains in close conjunction on its first page the designation, printed in a distinctly contrasting color in 24−point type, and the caption, printed in a distinctly contrasting color in 18−point type prescribed in sub. (5), (7) or (30);

5. Is substantially in the format prescribed in Appendix 1 to this section for the appropriate category and printed in no less than 12−point type;

6. Summarizes or refers to the coverage set out in applicable statutes;

7. Contains a listing of the required coverage as set out in sub. (5) (c) and the optional coverages as set out in sub. (5) (i), and the annual premiums therefor, substantially in the format of sub. (11) of Appendix 1; and

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8. Is approved by the commissioner along with the policy or certificate form.

(c) Any rider or endorsement added to the policy or certificate:

1. Shall be set forth in the policy or certificate and, if a separate, additional premium is charged in connection with the rider or endorsement, the premium charge shall be set forth in the policy or certificate; and

2. After the date of policy or certificate issue, shall be agreed to in writing signed by the insured, if the rider or endorsement increases benefits or coverage with an accompanying increase in premium during the term of the policy or certificate, unless the increase in benefits or coverage is required by law.

3. Shall only provide coverage as defined in sub. (5) (i) or provide coverage to meet statutory mandated provisions.

(d) The schedule of benefits page or the first page of the policy or certificate contains a listing giving the coverages and both the annual premium in the format shown in sub. (11) of Appendix 1 and modal premium selected by the applicant.

(e) The anticipated loss ratio for any new policy form, that is, the expected percentage of the aggregate amount of premiums earned which will be returned to insureds in the form of aggregate benefits, not including anticipated refunds or credits, provided under the policy form or certificate form:

1. Is computed on the basis of anticipated incurred claims or incurred health care expenses where coverage is provided by a health maintenance organizations on a service rather than reimbursement basis and earned premiums for the entire period for which the policy form provides coverage, in accordance with accepted actuarial principles and practices;

2. Is submitted to the commissioner along with the policy form and is accompanied by rates and an actuarial demonstration that expected claims in relationship to premiums comply with the loss ratio standards in sub. (16) (d). The policy form will not be approved unless the anticipated loss ratio along with the rates and actuarial demonstration show compliance.

(g) As regards subsequent rate changes to the policy form, the insurer:

1. Files such changes on a rate change transmittal form in a format specified by the commissioner.

2. Includes in its filing an actuarially sound demonstration that the rate change will not result in a loss ratio over the life of the policy which would violate sub. (16) (d).

(h) 1. Medicare supplement policies written prior to January 1, 1992, shall comply with the standards then in effect, except that the appropriate loss ratios specified in sub. (16) (d) shall be used to demonstrate compliance with minimum loss ratio requirements and refund calculations for policies and certificates renewed after December 31, 1995, and with sub. (14) (c).

2. For purposes of loss ratio and refund calculations, policies and certificates renewed after December 31, 1995, shall be treated as if they were issued in 1996.

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

1. Health status.

2. Claims experience.

3. Receipt of health care.

4. Medical condition.

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

(c) If an applicant qualifies under par. (a) and submits an application during the time period referenced in par. (a) and, as of the date of application, has had a continuous period of creditable coverage of at least 6 months, the issuer may not exclude benefits based on a preexisting condition.

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

(4s) MEDICARE SUPPLEMENT AND MEDICARE REPLACEMENT POLICY AND CERTIFICATE REQUIREMENTS FOR POLICIES AND CERTIFICATES WITH EFFECTIVE DATES ON OR AFTER JUNE 1, 2010. Except as explicitly allowed by subs. (5m) and (30m), no disability insurance policy or certificate shall relate its coverage to Medicare or be structured, advertised, marketed or issued for delivery in this state on or after June 1, 2010, as a Medicare supplement or as a Medicare replacement policy or certificate, as defined in s. 600.03 (28p) (a) and (c), Stats., unless it complies with the following:

(a) The policy or certificate:

1. Provides only the coverage set out in sub. (5m) or (30m) and applicable statutes and contains no exclusions or limitations other than those permitted by sub. (8). No issuer may issue a Medicare cost or Medicare select policy or certificate without prior approval from the commissioner and compliance with sub. (30m).

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

3. Contains no definitions of terms such as "Medicare eligible expenses," "accident," "sickness," "mental or nervous disorders," skilled nursing facility," "hospital," "nurse," "physician," "Medicare approved expenses," "benefit period," "convalescent nursing home," or "outpatient prescription drugs" that are worded less favorably to the insured person than the corresponding Medicare definition or the definitions contained in sub. (3), and defines "Medicare" as in accordance with sub. (3) (q).

4. Does not indemnify against losses resulting from sickness on a different basis from losses resulting from accident.

5. Is guaranteed renewable and does not provide for termination of coverage of a spouse solely because of an event specified for termination of coverage of the insured, other than the non−payment of premium. The policy or certificate may not be cancelled or nonrenewed by the issuer on the grounds of deterioration of health. The policy or certificate may be cancelled only for nonpayment of premium or material misrepresentation. If the policy or certificate is issued by a health maintenance organization, the policy or certificate may, in addition to the above reasons, be cancelled or nonrenewed by the issuer if the insured moves out of the service area.

6. Provides that termination of a Medicare supplement or Medicare cost policy or certificate shall be without prejudice to a continuous loss that commenced while the policy or certificate was in force, although the extension of benefits may be predicated upon the continuous total disability of the insured, limited to the duration of the policy or certificate benefit period, if any, or pay-

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ment of the maximum benefits. Receipt of the Medicare Part D benefits may not be considered in determining a continuous loss.

7. Contains statements on the first page and elsewhere in the policy or certificate that satisfy the requirements of s. Ins 3.13 (2) (c), (d) and (e), and clearly states on the first page or schedule page the duration of the term of coverage for which the policy or certificate is issued and for which it may be renewed. The renewal period cannot be less than the greatest of the following: 3 months, the period for which the insured has paid the premium, or the period specified in the policy or certificate.

8. Changes benefits automatically to coincide with any changes in the applicable Medicare deductible amount, coinsurance and copayment percentage factors, although there may be a corresponding modification of premiums in accordance with the policy or certificate provisions and ch. 625, Stats.

9. Prominently discloses any limitations on the choice of providers or geographical area of service.

10. Contains on the first page the designation, printed in 18−point type, and in close conjunction the caption printed in 12−point type, prescribed in sub. (5m) or (30m).

11. Contains text that is plainly printed in black or blue ink the size of which is uniform and not less than 10−point type with a lower−case unspaced alphabet length not less than 120−point type.

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

13. Is approved by the commissioner.

14. Contains no exclusion, limitation, or reduction of coverage for a specifically named or described condition after the policy or certificate effective date.

15. Provides for midterm cancellation at the request of the insured and provides that, if an insured cancels a policy or certificate midterm or the policy or certificate terminates midterm because of the insured's death, the issuer shall issue a pro rata refund to the insured or the insured's estate.

16. Except for permitted preexisting condition clauses as described in subd. 2., no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

17. No Medicare supplement policy or certificate in force in this state shall contain benefits that duplicate benefits provided by Medicare.

18. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period not to exceed 24 months in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to the assistance.

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

20. Each Medicare supplement policy or certificate shall provide, and contain within the policy or certificate, that benefits and premiums under the policy or certificate shall be suspended for any period that may be provided by federal regulation, at the request of the policyholder or certificateholder if the policyholder or certificateholder is entitled to benefits under section 226 (b) of the Social Security Act and is covered under a group health plan, as defined in section 1862 (b) (1) (A)(v) of the Social Security Act. If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy or certificate shall be automatically reinstituted, effective as of the date of loss of coverage, if the policyholder or certificateholder provides notice of loss of coverage within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

21. Reinstitution of such coverages:

a. May not provide for any waiting period with respect to treatment of preexisting conditions.

b. Shall provide for resumption of coverage that was in effect before the date of suspension in subd. 18.

c. Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

22. May not use an underwriting standard for persons who are under age 65 that is more restrictive than that used for persons age 65 and above.

(b) The outline of coverage for the policy or certificate shall comply with all of the following:

1. Is provided to all applicants at the same time application is made, and except in the case of direct response insurance, the issuer obtains written acknowledgement from the applicant that the outline was received.

2. Complies with s. Ins 3.27.

3. Is substituted to describe properly the policy or certificate as issued, if the outline provided at the time of application did not properly describe the coverage that was issued. The substituted outline shall accompany the policy or certificate when it is delivered and shall contain the following statement in no less than 12−point type and immediately above the company name: "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application, and the coverage originally applied for has not been issued."

4. Contains in close conjunction on its first page the designation, printed in a distinctly contrasting color or bold print in 24−point type, and the caption, printed in a distinctly contrasting color or bold print in 18−point type prescribed in sub. (5m), (7) or (30m).

5. Is substantially in the format prescribed in Appendices 3 through 6 to this section for the appropriate category and printed in no less than 12−point type.

6. Summarizes or refers to the coverage set out in applicable statutes.

7. Contains a listing of the required coverage as set out in sub. (5m) (d) and the optional coverage as set out in sub. (5m) (e), and the annual premiums for selected coverage, substantially in the format of sub. (11) in Appendix 2 to this section.

8. Is approved by the commissioner along with the policy or certificate form.

(c) Any rider or endorsement added to the policy or certificate shall conform to the following:

1. Shall be set forth in the policy or certificate and if a separate, additional premium is charged in connection with the rider or endorsement, the premium charge shall be set forth in the policy or certificate.

2. After the date of policy or certificate issue, any rider or endorsement added to the policy or certificate shall be agreed to in writing signed by the insured if the rider or endorsement

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increases benefits or coverages and there is an accompanying increase in premium during the term of the policy or certificate, unless the increase in benefits or coverage is required by law.

3. Shall only provide coverage as defined in sub. (5m) (e) or provide coverage to meet Wisconsin mandated benefits.

(d) The schedule of benefits page or the first page of the policy or certificate contains a listing giving the coverages and both the annual premium in the format shown in sub. (11) of Appendix 2 to this section and modal premium selected by the applicant.

(e) The anticipated loss ratio for any new policy or certificate form, that is, the expected percentage of the aggregate amount of premiums earned that will be returned to insureds in the form of aggregate benefits, not including anticipated refunds or credits, provided under the policy or certificate form:

1. Is computed on the basis of anticipated incurred claims or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the entire period for which the policy or certificate form provides coverage, in accordance with accepted actuarial principles and practices.

2. Is submitted to the commissioner along with the policy or certificate form and is accompanied by rates and an actuarial demonstration that expected claims in relationship to premiums comply with the loss ratio standards in sub. (16) (d). The policy or certificate form will not be approved unless the anticipated loss ratio along with the rates and actuarial demonstration show compliance.

(f) As regards subsequent rate changes to the policy or certificate form, the issuer:

1. Files such changes on a rate change transmittal form in a format specified by the commissioner.

2. Includes in its filing an actuarially sound demonstration that the rate change will not result in a loss ratio over the life of the policy or certificate that would violate sub. (16) (d).

(5) AUTHORIZED MEDICARE SUPPLEMENT POLICY AND CERTIFICATE DESIGNATION, CAPTIONS, REQUIRED COVERAGES, AND PERMISSIBLE ADDITIONAL BENEFITS FOR POLICIES OR CERTIFICATES EFFECTIVE PRIOR TO JUNE 1, 2010. For a policy or certificate to meet the requirements of sub. (4), that is issued or effective after December 31, 1990, and prior to June 1, 2010, it shall contain the authorized designation, caption and required coverage. A health maintenance organization shall place the letters HMO in front of the required designation on any approved Medicare supplement policy or certificate. A Medicare supplement policy or certificate shall include all of the following:

(a) The designation: MEDICARE SUPPLEMENT INSURANCE.

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

(c) The following required coverages, to be referred to as "Basic Medicare Supplement coverage" for a policy issued after December 31, 1990:

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

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

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

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

5. Payment of the usual and customary home care expenses to a minimum of 40 visits per 12−month period as required under s. 632.895 (1) and (2), Stats., and s. Ins 3.54;

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

7. In group policies, nervous and mental disorder and alcoholism and other drug abuse coverage as required under s. 632.89, Stats.;

8. Payment in full for all usual and customary expenses for chiropractic services required by s. 632.87 (3), Stats. Issuers are not required to duplicate benefits paid by Medicare;

9. Coverage for the first 3 pints of blood payable under Part B;

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

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

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

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

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

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

16. Payment in full for all usual and customary expenses of hospital and ambulatory surgery center charges and anesthetics for dental care required by s. 632.895 (12), Stats. Issuers are not required to duplicate benefits paid by Medicare.

17. Payment in full for all usual and customary expenses for breast reconstruction required by s. 632.895 (13), Stats. Issuers are not required to duplicate benefits paid by Medicare.

(i) Permissible additional coverage only added to the policy as separate riders. The issuer shall issue a separate rider for each coverage the issuer chooses to offer. Issuers shall ensure that the riders offered are compliant with MMA, that each rider is priced sep-

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arately, available for purchase separately at any time, subject to underwriting and the pre−existing limitation allowed in sub. (4) (a) 2., and may consist of the following:

1. Coverage for the Medicare Part A hospital deductible. The rider shall be designated: MEDICARE PART A DEDUCTIBLE RIDER;

2. Coverage for home health care for an aggregate of 365 visits per policy year as required by s. 632.895 (1) and (2), Stats. The rider shall be designated as: ADDITIONAL HOME HEALTH CARE RIDER;

3. Coverage for the Medicare Part B medical deductible. The rider shall be designated as: MEDICARE PART B DEDUCTIBLE RIDER;

4. Coverage for the difference between Medicare's Part B eligible charges and the amount charged by the provider which shall be no greater than the actual charge or the limiting charge allowed by Medicare. The rider shall be designated as: MEDICARE PART B EXCESS CHARGES RIDER;

5. Coverage for benefits obtained outside the United States. An issuer which offers this benefit shall not limit coverage to Medicare deductibles and copayments. Coverage may contain a deductible of up to $250. Coverage shall pay at least 80% of the billed charges for Medicare−eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during at least the first 60 consecutive days of each trip outside the United States and a lifetime maximum benefit of at least $50,000. For purposes of this benefit, "emergency hospital, physicians and medical care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset. The rider shall be designated as: FOREIGN TRAVEL RIDER.

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

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

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

1. The designation: MEDICARE SUPPLEMENT INSURANCE − HIGH DEDUCTIBLE PLAN.

2. 100% of the covered benefits described in pars. (c) and (i) 1., 2., 3., 4. and 5. following the payment of the annual high deductible.

3. The annual high deductible shall consist of out−of−pocket expenses, other than premiums, for services covered in subd. 2. and shall be in addition to any other specific benefit deductibles.

4. The annual high deductible shall be $1500 for 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve−month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

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

1. The designation: MEDICARE SUPPLEMENT INSURANCE − HIGH DEDUCTIBLE DRUG PLAN.

2. 100% of the covered benefits described in pars. (c) and (i) 1., 2., 3., 4., 5. and 7. following the payment of the annual high deductible.

3. The annual high deductible shall consist of out−of−pocket expenses, other than premiums, for services covered in subd. 2. and shall be in addition to any other specific benefit deductibles.

4. The annual high deductible shall be $1500 for 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve−month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

(n) For the Medicare Supplement 50% Cost−Sharing plans, only the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(5m) AUTHORIZED MEDICARE SUPPLEMENT POLICY AND CERTIFICATE DESIGNATION, CAPTIONS, REQUIRED COVERAGES, AND PERMISSIBLE ADDITIONAL BENEFITS FOR POLICIES OR CERTIFICATES WITH EFFECTIVE DATES ON OR AFTER JUNE 1, 2010. (a) 1. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued in this state. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. Benefit standards applicable to Medicare supplement policies and certificates with effective dates prior to June 1, 2010 remain subject to the applicable requirements contained in sub. (5).

2. For a policy or certificate to meet the requirements of sub. (4s), it shall contain the authorized designation, caption and required coverage. A health maintenance organization shall place the letters HMO in front of the required designation on any approved Medicare supplement policy or certificate. A Medicare supplement policy or certificate shall include all of the following:

(b) The designation: MEDICARE SUPPLEMENT INSURANCE.

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

(d) The following required coverages shall be referred to as "Basic Medicare Supplement Coverage":

1. Coverage of at least 175 days per lifetime for inpatient psychiatric hospital care upon exhaustion of Medicare hospital inpatient psychiatric coverage.

2. Coverage of coinsurance or copayments for Medicare Part A eligible expenses in a skilled nursing facility from the 21st through the 100th day in a benefit period.

3. Coverage for all Medicare Part A eligible expenses for the first 3 pints of blood or equivalent quantities of packed red blood cells to the extent not covered by Medicare.

4. Coverage of coinsurance or copayments for all Medicare Part A eligible expenses for hospice and respite care.

5. Coverage of coinsurance or copayment for Medicare Part B eligible expenses to the extent not paid by Medicare, or in the case of hospital outpatient department services paid under a prospective payment system including outpatient psychiatric care, regardless of hospital confinement, subject to the Medicare Part B calendar year deductible.

6. Coverage for the usual and customary home care expenses to a minimum of 40 visits per 12−month period as required under s. 632.895 (1) and (2), Stats., and s. Ins 3.54.

7. Coverage for skilled nursing care and kidney disease treatment as required under s. 632.895 (3) and (4), Stats. Coverage for skilled nursing care shall be in addition to the required coverage under subd. 1, payment of coinsurance or copayment for Medicare Part A eligible skilled nursing care may not count as satisfying the coverage requirement of at least 30 days of non−Medicare eligible skilled nursing care under s. 632.895 (3), Stats.

8. In group policies, coverage for nervous and mental disorder and alcoholism and other drug abuse coverage as required under s. 632.89, Stats.

9. Coverage in full for all usual and customary expenses for chiropractic services required by s. 632.87 (3), Stats. Issuers are not required to duplicate benefits paid by Medicare.

10. Coverage of the first 3 pints of blood payable under Medicare Part B.

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

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

13. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of all Medicare Part A eligible expenses for hospitalization not covered by Medicare for an additional 365 days to the extent the hospital is permitted to charge Medicare by federal law and regulation and subject to the Medicare reimbursement rate and a lifetime maximum benefit. The provider shall accept the issuer's payment as payment in full and may not balance bill the insured.

14. Coverage in accordance with s. 632.895 (6), Stats., for treatment of diabetes including non−prescription insulin or any other non−prescription equipment and supplies for the treatment

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of diabetes, but not including any other outpatient prescription medications. Issuers are not required to duplicate expenses paid by Medicare.

15. Coverage for preventive health care services not covered by Medicare and as determined to be medically appropriate by an attending physician. These benefits shall be included in the basic policy or certificate. Reimbursement shall be for the actual charges up to 100% of the Medicare approved amount for each service, as if Medicare were to cover the service, as identified in the American Medical Association Current Procedural Terminology codes, to a minimum of $120 annually under this benefit. This benefit may not include payment for any procedure covered by Medicare.

16. Coverage in full for all usual and customary expenses of hospital and ambulatory surgery center charges and anesthetics for dental care required by s. 632.895 (12), Stats. Issuers are not required to duplicate benefits paid by Medicare.

17. Coverage in full for all usual and customary expenses for breast reconstruction required by s. 632.895 (13), Stats. Issuers are not required to duplicate benefits paid by Medicare.

(e) Permissible coverage options may only be added to the policy or certificate as separate riders. The issuer shall issue a separate rider for each option offered. Issuers shall ensure that the riders offered are compliant with MMA, each rider is priced separately, available for purchase separately at any time, subject to underwriting and the preexisting limitation allowed in sub. (4s) (a) 2. The issuer shall not issue to the same insured for the same period of coverage both the Medicare Part A Deductible rider and the Medicare 50% Part A Deductible rider. The issuer shall not issue to the same insured for the same period of coverage both the Medicare Part B Deductible rider and the Medicare Part B Copayment or Coinsurance rider. Separate riders, if offered, shall consist of the following:

1. Coverage of 100% of the Medicare Part A hospital deductible. The rider shall be designated: MEDICARE PART A DEDUCTIBLE RIDER.

2. Coverage of 50% of the Medicare Part A hospital deductible per benefit period with no out−of−pocket maximum. The rider shall be designated: MEDICARE 50% PART A DEDUCTIBLE RIDER.

3. Coverage of home health care for an aggregate of 365 visits per policy or certificate year as required by s. 632.895 (1) and (2), Stats. The rider shall be designated as: ADDITIONAL HOME HEALTH CARE RIDER.

4. Coverage of 100% of the Medicare Part B medical deductible. The rider shall be designated as: MEDICARE PART B DEDUCTIBLE RIDER.

5. Medicare Part B Copayment or Coinsurance Rider. Under this option, the insured's copayment or coinsurance will be the lesser of $20 per office visit or the Medicare Part B coinsurance and the lesser of $50 per emergency room visit or the Medicare Part B coinsurance that is in addition to the Medicare Part B medical deductible. The emergency room copayment or coinsurance fee shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense. The rider shall be designated as: MEDICARE PART B COPAYMENT OR COINSURANCE RIDER.

6. Coverage of the difference between Medicare Part B eligible charges and the amount charged by the provider that shall be no greater than the actual charge or the limiting charge allowed by Medicare. The rider shall be designated as: MEDICARE PART B EXCESS CHARGES RIDER.

7. Coverage for services obtained outside the United States. An issuer that offers this benefit may not limit coverage to Medicare deductibles, coinsurance and copayments. Coverage may contain a deductible of up to $250. Coverage shall pay at least 80% of the billed charges for Medicare−eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country; which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States for up to a lifetime maximum benefit of at least $50,000. For purposes of this benefit, "emergency hospital, physicians and medical care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset. The rider shall be designated as: FOREIGN TRAVEL EMERGENCY RIDER.

(f) For HMO Medicare select policies, only the benefits specified in sub. (30m) (p), (r) and (s), may be offered in addition to Medicare benefits.

(g) For the Medicare supplement 50% Cost−Sharing plans, only the following:

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

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

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

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

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

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

7. Coverage for 50% of coinsurance or copayments for all Medicare Part A eligible expenses and respite care until the out−of−pocket limitation is met as described in subd. 12.

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

9. Except for coverage provided in subd. 11., coverage for 50% of the coinsurance or copayment otherwise applicable under Medicare Part B after the policyholder or certificateholder pays the Medicare Part B deductible until the out−of−pocket limitation is met as described in subd. 12.

10. Coverage for 100% of the coinsurance or copayments for the benefits described in pars. (d) 1., 6., 7., 9., 14., 16., and 17., and (e) 3., to the extent the benefits do not duplicate benefits paid by Medicare and after the policyholder or certificateholder pays the Medicare Part A and B deductibles and meets the out−of−pocket limitation described in subd. 12.

11. Coverage for 100% of the coinsurance or copayments for Medicare Part B preventive services after the policyholder or certificateholder pays the Medicare Part B deductible.

12. Coverage for 100% of all cost sharing under Medicare Part A or B for the balance of the calendar year after the individual has reached the out−of−pocket limitation on annual expenditures under Medicare Parts A and B of [$4,440], indexed each year by the appropriate inflation adjustment specified by the Secretary.

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(h) For the Medicare Supplement 25% Cost−Sharing plans, only the following:

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

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

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

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

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

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

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

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

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

10. Coverage for 100% of the cost sharing for the benefits described in pars. (d) 1., 6., 7., 9., 14., 16., and 17., and (e) 3., to the extent the benefits do not duplicate benefits paid by Medicare and after the policyholder or certificateholder pays the Medicare Part A and B deductible and meets the out−of−pocket limitation described in subd. 12.

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

12. Coverage for 100% of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out−of−pocket limitation on annual expenditures under Medicare Parts A and B of [$2,220], indexed each year by the appropriate inflation adjustment specified by the Secretary.

(k) For the Medicare supplement high deductible plan, the following:

1. The designation: MEDICARE SUPPLEMENT INSURANCE−HIGH DEDUCTIBLE PLAN.

2. Coverage for 100% of benefits described in pars. (d) and (e) 1., 3., 4., 6., and 7., following the payment of the annual high deductible.

3. The annual high deductible shall consist of out−of−pocket expenses, other than premiums, for services covered in subd. 2 and shall be in addition to any other specific benefit deductibles.

4. The annual high deductible shall be $2000 and shall be adjusted annually by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the twelve−month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

(6) USUAL, CUSTOMARY AND REASONABLE CHARGES. An issuer can only include a policy or certificate provision limiting benefits to the usual, customary and reasonable charge as determined by the issuer for coverages described in subs. (5) (c) 5., 8. and 13., or (5m) (d) 6., 9., and 14. If the issuer includes such a provision, the issuer shall:

(a) Define those terms in the policy or rider and disclose to the policyholder that the UCR charge may not equal the actual charge, if this is true.

(b) Have reasonable written standards based on similar services rendered in the locality of the provider to support benefit determination which shall be made available to the commissioner on request.

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

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

2. The caption, except that the word "certificate" may be used instead of "policy," if appropriate: "The Wisconsin Insurance Commissioner has set minimum standards for Medicare cost insurance. This policy meets these standards. For an explanation of these standards and other important information, see 'Wisconsin Guide to health Insurance for People with Medicare,' given to you when you bought this policy. Do not buy this policy if you did not get this guide;"

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

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

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

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

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

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

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

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

11. Coverage for preventive health care services not covered by Medicare and as determined to be medically appropriate by an attending physician. If offered, these benefits shall be included in the basic policy. Reimbursement shall be for the actual charges up to 100% of the Medicare approved amount for each service, as if Medicare were to cover the service, as identified in the American Medical Association Current Procedural Terminology (AMA CPT) codes, to a minimum of $120 annually under this benefit.

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This benefit shall not include payment for any procedure covered by Medicare.

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

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

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

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

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

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

(c) Each Medicare cost issuer, as defined in s. 600.03 (28p) (a) and (c), Stats., may offer an enhanced Medicare cost plan that contain the coverage contained in sub. (5) (c) 5., 6., 7., 8., 13., 15., 16., 17., and the riders described in sub. (5) (i) and other coverages as authorized by CMS.

(cm) For Medicare cost policies issued on or after June 1, 2010, each Medicare cost issuer, as defined in s. 600.03 (28p) (a) and (c), Stats., may offer an enhanced Medicare cost plan that contain the coverage contained in sub. (5m) (d) 6., 7., 8., 10., 14., 16., and 17., and the riders described in sub. (5m) and other coverages as authorized by CMS.

(d) In addition to all other subsections that are applicable to Medicare cost policies, the marketing of Medicare cost policies shall comply with the requirements of Medicare supplement policies contained in subs. (15), (21), (24), and (25). The outline of coverage listed in Appendix 1 and the replacement form specified in Appendix 7 shall be modified to accurately reflect the benefit, exclusions and other requirements that differ from Medicare supplement policies approved under sub. (5).

(dm) For Medicare cost policies issued on or after June 1, 2010, in addition to all other subsections that are applicable to Medicare cost policies, the marketing of Medicare cost policies shall comply with the requirements of Medicare supplement policies contained in subs. (15), (21), (24) and (25). The outline of coverage listed in Appendix 2 and the replacement form specified in Appendix 7 shall be modified to accurately reflect the benefits, exclusions and other requirements that differ from Medicare supplement policies approved under sub. (5m).

(8) PERMISSIBLE MEDICARE SUPPLEMENT AND MEDICARE REPLACEMENT POLICY OR CERTIFICATE EXCLUSIONS AND LIMITATIONS. (a) The coverage set out in subs. (5), (5m), (7), (30) and (30m), as applicable:

1. Shall exclude expenses for which the insured is compensated by Medicare;

2. May contain an appropriate provision relating to the effect of other insurance on claims;

3. May contain a pre−existing condition waiting period provision as provided in sub. (4) (a) 2., which shall appear as a separate paragraph on the first page of the policy and shall be captioned or titled "Pre−existing Condition Limitations;" and

4. May, if issued by a health maintenance organization as defined by s. 609.01 (2), Stats., include territorial limitations which are generally applicable to all coverage issued by the plan.

5. May exclude coverage for the treatment of service related conditions for members or ex−members of the armed forces by any military or veterans hospital or soldier home or any hospital contracted for or operated by any national government or agency.

(b) If the insured chooses not to enroll in Medicare Part B, the issuer may exclude from coverage the expenses which Medicare Part B would have covered if the insured were enrolled in Medicare Part B. An issuer may not exclude Medicare Part B eligible expenses incurred beyond what Medicare Part B would cover.

(c) The coverages set out in subs. (5), (5m), (7), (30), and (30m) may not exclude, limit, or reduce coverage for specifically named or described preexisting diseases or physical conditions, except as provided in par. (a) 3.

(e) A Medicare replacement policy and Medicare supplement policy may include other exclusions and limitations which are not otherwise prohibited and are not more restrictive than exclusions and limitations contained in Medicare.

(9) INDIVIDUAL POLICIES PROVIDING NURSING HOME, HOSPITAL CONFINEMENT INDEMNITY, SPECIFIED DISEASE AND OTHER COVERAGES. (a) *Caption requirements.* Captions required by this subsection shall be:

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

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

3. Printed in 18−point bold letters.

(b) *Disclosure statements.* The appropriate disclosure statement from Appendix 10 shall be used on the application or together with the application for each coverage in pars. (c) to (e). The disclosure statement may not vary from the text or format including bold characters, line spacing, and the use of boxes around text contained in Appendix 10 and shall use a type size of at least 12 points. The issuer may use either (a) or (aL), (b) or (bL), (c) or (cL) or (g) or (gL) providing the issuer uses the same disclosure statement for all policies of the type covered by the disclosure.

(c) *Hospital confinement indemnity coverage.* An individual policy form providing hospital confinement indemnity coverage sold to a Medicare eligible person:

1. Shall not include benefits for nursing home confinement unless the nursing home coverage meets the standards set forth in s. Ins 3.46;

2. Shall bear the caption, if the policy provides no other types of coverage: "This policy is not designed to fill the gaps in Medicare. It will pay you only a fixed dollar amount per day when you are confined to a hospital. For more information, see "Wisconsin Guide to Health Insurance for People with Medicare', given to you when you applied for this policy."

3. Shall bear the caption set forth in par. (e), if the policy provides other types of coverage in addition to the hospital confinement indemnity coverage.

(d) *Specified disease coverage.* An individual policy form providing benefits only for one or more specified diseases sold to a Medicare eligible person shall bear:

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

2. The caption: "This policy covers only one or more specified or rare illnesses. It is not a substitute for a broader policy which would generally cover any illness or injury. For more information, see 'Wisconsin Guide to Health Insurance for People with Medicare', given to you when you applied for this policy."

(e) *Other coverage.* An individual disability policy sold to a Medicare eligible person, other than a form subject to sub. (5) or

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(7) or otherwise subject to the caption requirements in this subsection or exempted by sub. (2) (d) or (e), shall bear the caption: "This policy is not a Medicare supplement. For more information, see "Wisconsin Guide to Health Insurance for People with Medicare', given to you when you applied for this policy."

(10) CONVERSION OR CONTINUATION OF COVERAGE. (a) Conversion requirements. An insured under individual, family, or group hospital or medical coverage who will become eligible for Medicare and is offered a conversion policy which is not subject to subs. (4) and (5) or (7) shall be furnished by the issuer, at the time the conversion application is furnished in the case of individual or family coverage or within 14 days of a request in the case of group coverage:

1. An outline of coverage as described in par. (d) and

2. A copy of the current edition of the pamphlet described in sub. (11).

(b) Continuation requirements. An insured under individual, family, or group hospital or medical coverage who will become eligible for Medicare and whose coverage will continue with changed benefits (e.g., "carve−out" or reduced benefits) shall be furnished by the issuer, within 14 days of a request:

1. A comprehensive written explanation of the coverage to be provided after Medicare eligibility, and

2. A copy of the current edition of the pamphlet described in sub. (11).

(c) Notice to group policyholder. An issuer which provides group hospital or medical coverage shall furnish to each group policyholder:

1. Annual written notice of the availability of the materials described in pars. (a) and (b), where applicable, and

2. Within 14 days of a request, sufficient copies of the same or a similar notice to be distributed to the group members affected.

(d) Outline of coverage. The outline of coverage:

1. For a conversion policy which relates its benefits to or complements Medicare, shall comply with sub. (4) (b) 2., 5. and 7. of this section and shall be submitted to the commissioner; and

2. For a conversion policy not subject to subd. 1., shall comply with sub. (9), where applicable, and s. Ins 3.27 (5) (L).

(11) "WISCONSIN GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE" PAMPHLET. Every prospective Medicare eligible purchaser of any policy or certificate subject to this section which provides hospital or medical coverage, other than incidentally, or of any coverage added to an existing Medicare supplement policy or certificate, except any policy subject to s. Ins 3.46, shall receive a copy of the current edition of the commissioner's pamphlet "Wisconsin Guide to Health Insurance for People with Medicare" in a type size no smaller than 12 point type at the time the prospect is contacted by an intermediary or issuer with an invitation to apply as defined in s. Ins 3.27 (5) (g). Except in the case of direct response insurance, written acknowledgement of receipt of this pamphlet shall be obtained by the issuer. This pamphlet provides information on Medicare and advice to people on Medicare on the purchase of Medicare supplement insurance and other health insurance. Issuers may obtain information from the commissioner's office on how to obtain copies or may reproduce this pamphlet themselves. This pamphlet may be periodically revised to reflect changes in Medicare and any other appropriate changes. No issuer shall be responsible for providing applicants the revised pamphlet until 30 days after the issuer has been given notice that the revised pamphlet is available.

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

(13) EXEMPTION OF CERTAIN POLICIES AND CERTIFICATES FROM CERTAIN STATUTORY MEDICARE SUPPLEMENT REQUIREMENTS. Policies and certificates defined in sub. (2) (d), even if they are Medicare supplement policies as defined in s. 600.03 (28r), Stats., or Medicare replacement policies as defined in s. 600.03 (28p) (a) and (c), Stats., shall not be subject to either of the following:

(a) The special right of return provision for Medicare supplement policies set forth in s. 632.73 (2m), Stats., and s. Ins 3.13 (2) (j) 3.

(b) The special pre−existing diseases provisions for Medicare supplement policies set forth in s. 632.76 (2) (b), Stats.

(14) OTHER REQUIREMENTS FOR POLICIES OR CERTIFICATES WITH EFFECTIVE DATES PRIOR TO JUNE 1, 2010. (a) Each issuer issuing policies or certificates with effective dates prior to June 1, 2010, may file and utilize only one individual Medicare supplement policy form, one individual Medicare select policy form, one individual Medicare replacement policy form and one group Medicare supplement policy form with any of the accompanying riders permitted in sub. (5) (i), unless the commissioner approves the use of additional forms and the issuer agrees to aggregate experience for the various forms in calculating rates and loss ratios.

(b) An issuer shall mail any refund or return of premium directly to the insured and may not require or permit delivery by an agent or other representative.

(c) An issuer shall comply with section 1882 (c) (3) of the Social Security Act, as enacted by section 4081 (b) (2) (C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100−203, by:

1. Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

2. Notifying the participating physician or supplier and the beneficiary of the payment determination;

3. Paying the participating physician or supplier directly;

4. Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;

5. Paying user fees for claim notices that are transmitted electronically or otherwise;

6. Providing to the Secretary, at least annually, a central mailing address to which all claims may be sent by Medicare carriers; and

7. Certifying compliance with the requirements set forth in this subsection on the Medicare supplement insurance experience reporting form.

(d) Except as provided in subd. 1., an issuer shall continue to make available for purchase any policy form or certificate form issued after August 1, 1992 that has been approved by the commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.

1. An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner, the issuer shall no longer offer for sale the policy form or certificate form in this state.

2. An issuer that discontinues the availability of a policy form or certificate form pursuant to subd. 1., shall not file for approval a new policy form or certificate form of the same type as the discontinued form for a period of 5 years after the issuer provides notice to the commissioner of the discontinuance. The period of

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discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

3. This subsection shall not apply to the riders permitted in sub. (5) (i).

(e) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

(f) A change in the rating structure or methodology shall be considered a discontinuance under par. (d) 1. unless the issuer complies with the following requirements:

1. The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and resultant rates.

2. The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential which is in the public interest.

(g) Except as provided in par. (h) the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in sub. (31).

(h) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

(i) No issuer may issue a Medicare supplement policy or a certificate to an applicant 75 years of age or older, unless the applicant is subject to sub. (4m) or, prior to issuing coverage, the issuer either agrees not to rescind or void the policy except for intentional fraud in the application, or obtains one of the following:

1. A copy of a physical examination.

2. An assessment of functional capacity.

3. An attending physician's statement.

4. Copies of medical records.

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

(k) If an issuer nonrenews an insured who has a nonguaranteed renewable Medicare supplement policy with the issuer, the issuer shall at the time any notice of nonrenewal is sent to the insured, offer a currently available individual replacement Medicare supplement policy and those currently available riders resulting in coverage substantially similar to coverage provided by the replaced policy without underwriting. This replacement shall comply with sub. (27).

(L) For policies issued between December 31, 1980, and January 1, 1992, issuers shall combine the Wisconsin experience of all policy forms of the same type (individual or group) for the purposes of calculating the loss ratio under sub. (16) (c) and rates. The rates for all such policies of the same type shall be adjusted by the same percentage. Issuers may combine the Wisconsin experience of all policies issued prior to January 1, 1981, with those issued between December 31, 1980, and January 1, 1992, if the issuer uses the 60% loss ratio for individual policies and the 70% loss ratio for group policies renewed prior to January 1, 1996, and the appropriate loss ratios specified in sub. (16) (d) thereafter. If the Wisconsin experience is not credible, then national experience can be considered.

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

(14m) OTHER REQUIREMENTS FOR POLICIES OR CERTIFICATES WITH EFFECTIVE DATES ON OR AFTER JUNE 1, 2010. (a) Each issuer issuing policies or certificates with effective dates on or after June 1, 2010, may file and utilize only one individual Medicare supplement policy or certificate form, one individual Medicare select policy or certificate form, one individual Medicare replacement policy or certificate form and one group Medicare supplement policy or certificate form with any of the accompanying riders permitted in sub. (5m) (e), unless the commissioner approves the use of additional forms and the issuer agrees to aggregate experience for the various forms in calculating rates and loss ratios.

(b) An issuer shall mail any refund or return of premium directly to the insured and may not require or permit delivery by an agent or other representative.

(c) An issuer shall comply with section 1882 (c) (3) of the Social Security Act, as enacted by section 4081 (b) (2) (C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100−203, by complying with all of the following:

1. Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

2. Notifying the participating physician or supplier and the beneficiary of the payment determination;

3. Paying the participating physician or supplier directly;

4. Furnishing, at the time of enrollment, each enrollee with a card listing the policy or certificate name, number and a central mailing address to which notices from a Medicare carrier may be sent;

5. Paying user fees for claim notices that are transmitted electronically or otherwise;

6. Providing to the Secretary, at least annually, a central mailing address to which all claims may be sent by Medicare carriers; and

7. Certifying compliance with the requirements set forth in this subsection on the Medicare supplement insurance experience reporting form.

(d) Except as provided in subd. 1., an issuer shall continue to make available for purchase any policy form or certificate form issued after May 31, 2010, that has been approved by the commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.

1. An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner, the issuer shall no longer offer for sale the policy form or certificate form in this state.

2. An issuer that discontinues the availability of a policy form or certificate form pursuant to subd. 1., shall not file for approval a new policy form or certificate form of the same type as the discontinued form for a period of 5 years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

3. This subsection shall not apply to the riders permitted in sub. (5m) (e).

(e) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

(f) A change in the rating structure or methodology shall be considered a discontinuance under par. (d) 1. unless the issuer complies with the following requirements:

1. The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the man-

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ner in which the revised rating methodology and resultant rates differ from the existing rating methodology and resultant rates.

2. The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential that is in the public interest.

(g) Except as provided in par. (h) the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in sub. (31).

(h) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

(i) No issuer may issue a Medicare supplement policy or certificate to an applicant 75 years of age or older, unless the applicant is subject to sub. (4m) or, prior to issuing coverage, the issuer either agrees not to rescind or void the policy or certificate except for intentional fraud in the application, or obtains one of the following:

1. A copy of a physical examination.
2. An assessment of functional capacity.
3. An attending physician's statement.
4. Copies of medical records.

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

(k) If an issuer nonrenews an insured who has a nonguaranteed renewable Medicare supplement policy or certificate with the issuer, the issuer shall at the time any notice of nonrenewal is sent to the insured, offer a currently available individual replacement Medicare supplement policy or certificate and those currently available riders resulting in coverage substantially similar to coverage provided by the replaced policy or certificate without underwriting. This replacement shall comply with sub. (27).

(L) For policies or certificates issued with an effective date on or after June 1, 2010, issuers shall combine the Wisconsin experience of all policy or certificate forms of the same type (individual or group) for the purposes of calculating the loss ratio under sub. (16) (c) and rates. The rates for all such policies or certificates of the same type shall be adjusted by the same percentage. If the Wisconsin experience is not credible, then national experience can be considered.

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

(15) FILING REQUIREMENTS FOR ADVERTISING. Prior to use in this state, every issuer shall file with the commissioner a copy of any advertisement used in connection with the sale of Medicare supplement or Medicare cost policies issued with an effective date after December 31, 1989. If the advertisement does not reference a particular issuer or Medicare supplement or Medicare cost policy or certificate, each agent utilizing the advertisement shall file the advertisement with the commissioner on a form specified by the commissioner. The advertisements shall comply with all applicable laws and rules of this state.

Note: A copy of the advertisement filing form required under sub. (15), OCI 26−042, may be obtained at no cost from the Office of the Commissioner of Insurance, P.O. Box 7873, Madison, WI, 53707−7873 or from the OCI website address: http://oci.wi.gov.

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

(b) The supporting documentation shall also demonstrate in accordance with the actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. Such demonstration shall exclude active life reserves. An expected 3rd year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than 3 years.

(c) As soon as practicable, but no later than October 1 of the year prior to the effective date of enhancements in Medicare benefits, every issuer providing Medicare supplement or Medicare cost policies or certificates in this state shall file with the commissioner in accordance with the applicable filing procedures of this state appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the current premium for the applicable policies or certificates. Supporting documents as necessary to justify the adjustment shall accompany the filing.

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

2. If an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this subsection.

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

(d) For purposes of subs. (4) (e), (14) (L) and this subsection, the loss ratio standards shall be:

1. At least 65% in the case of individual policies.
2. At least 75% in the case of group policies, and
3. For existing policies subject to this subsection, the loss ratio shall be calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices.

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

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prescribed by the commissioner and in accordance with sub. (4) (g).

(17) NEW OR INNOVATIVE BENEFITS. An issuer may offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards and is filed and approved by the commissioner. The new or innovative benefits may include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available and are cost−effective. New or innovative benefits may not include an outpatient prescription drug benefit. New or innovative benefits may not be used to change or reduce benefits, including a change of any cost−sharing provision.

(18) ELECTRONIC ENROLLMENT. (a) Any requirement that a signature of an insured be obtained by an agent or issuer offering any Medicare supplement or replacement plans shall be satisfied if all of the following are met:

1. The consent of the insured is obtained by telephonic or electronic enrollment by the issuer or group policyholder or certificateholder. A verification of the enrollment information shall be provided in writing to the applicant with the delivery of the policy or certificate.

2. The telephonic or electronic enrollment provides necessary and reasonable safeguards to ensure the accuracy, retention and prompt retrieval of records as required pursuant to ch. 137, subch. II, Stats.

3. The telephonic or electronic enrollment provides necessary and reasonable safeguards to ensure that the confidentiality of personal financial and health information as defined in s. 610.70, Stats., and ch. Ins 25 is maintained.

(b) The issuer shall make available, upon request of the commissioner, records that demonstrate the issuer's ability to confirm enrollment and coverage.

(21) COMMISSION LIMITATIONS. (a) An issuer may provide and an agent or other representative may accept commission or other compensation for the sale of a Medicare supplement or Medicare cost policy or certificate only if the first year commission or other first year compensation is at least 100% and no more than 150% of the commission or other compensation paid for selling or servicing the policy or certificate in the 2nd year.

(b) The commission or other compensation provided in subsequent renewal years shall be the same as that provided in the 2nd year or period and shall be provided for at least 5 renewal years.

(c) If an existing policy or certificate is replaced, no entity may provide compensation to its producers and no agent or producer may receive compensation greater than the renewal compensation payable by the replacing issuer on the policy or certificate.

(d) For purposes of this section, "compensation" includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards, finder's fees, and policy fees.

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

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

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

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

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

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

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

2. Inform each policyholder or certificateholder as to when any premium adjustment is to be made due to changes in Medicare.

(g) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

(h) Such notices shall not contain or be accompanied by any solicitation.

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

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

[Statements]

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

2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

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

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

5. If you are eligible for and have enrolled in a Medicare supplement or Medicare cost policy by reason of disability and you later become covered by an employer or union−based group health plan, the benefits and premiums under your Medicare supplement or Medicare cost policy can be suspended, if requested, while you are covered under the employer or union−based group health plan. If you suspend your Medicare supplement or Medicare cost policy under these circumstances, and later lose your employer or union−based group health plan, your suspended Medicare supplement or Medicare cost policy or, if that is no longer available, a substantially equivalent policy will be reinstituted if requested within 90 days of losing your employer or union−based group health plan. If the Medicare supplement or Medicare cost policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

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

[Questions]

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

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

To the best of your knowledge,

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

Yes _____ No _____

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

Yes _____ No _____

c. If yes, what is the effective date?

_____

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

Yes _____ No _____

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

If yes,

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

Yes _____ No _____

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

Yes _____ No _____

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

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

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

Yes _____ No _____

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

Yes _____ No ____

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

Yes _____ No _____

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

Yes _____ No _____

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

_____

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

Yes _____ No _____

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

Yes _____ No _____

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

_____

_____

_____

_____

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

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

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

(b) Agents shall list, in a supplementary form signed by the agent and submitted to the issuer with each application for Medicare supplement coverage, any other health insurance policies they have sold to the applicant as follows:

1. Any policy sold which is still in force.

2. Any policy sold in the past 5 years which is no longer in force.

(bL) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the issuer, shall be returned to the applicant by the issuer upon delivery of the policy.

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

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be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the solicitation of the policy the notice regarding replacement of accident and sickness coverage.

(d) The notice required by par. (c) for an issuer shall be provided in substantially the form as shown in Appendix 7.

(e) If the application contains questions regarding health, include a statement that health questions should not be answered if the applicant is in the open−enrollment period described in sub. (4m).

(24) STANDARDS FOR MARKETING. (a) Every issuer marketing Medicare supplement insurance coverage in this state, directly or through its producers, shall:

1. Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

2. Establish marketing procedures to assure excessive insurance is not sold or issued.

3. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance.

(b) Every issuer marketing Medicare supplement insurance shall establish auditable procedures for verifying compliance with par. (a).

(c) In addition, the following acts and practices are prohibited:

1. 'Twisting.' Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or issuers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another issuer.

2. 'High pressure tactics.' Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

3. 'Cold lead advertising.' Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose is solicitation of the purchase of insurance and that contact will be made by an agent or issuer.

(e) In regards to any transaction involving a Medicare supplement policy, no person subject to regulation under chs. 600 to 655, Stats., may knowingly prevent or dissuade or attempt to prevent or dissuade, any person from:

1. Filing a complaint with the office of the commissioner of insurance; or

2. Cooperating with the office of the commissioner of insurance in any investigation; or

3. Attending or giving testimony at any proceeding authorized by law.

(f) If an insured exercises the right to return a policy during the free−look period, the issuer shall mail the entire premium refund directly to the person who paid the premium.

(g) The terms "Medicare Supplement," "Medigap," "Medicare Wrap Around," and "Medicare Advantage Supplement" and words of similar import may not be used in any materials including advertisements as defined in s. Ins 3.27 (5) (a), unless the policy or certificate is issued in compliance with this section.

(25) APPROPRIATENESS OF RECOMMENDED PURCHASE AND EXCESSIVE INSURANCE. (a) In recommending the purchase or replacement of any Medicare supplement or Medicare replacement policy or certificate, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

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

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

(d) An agent may not take and an issuer may not accept an application from an insured more than 3 months prior to the insured becoming eligible.

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

1. Policy and certificate number, and

2. Date of issuance.

(b) The items in par. (a) must be grouped by individual policyholder or certificateholder and listed on a form in substantially the same format as Appendix 9 on or before March 1 of each year.

(27) WAITING PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES. If a Medicare supplement or Medicare cost policy or certificate replaces another Medicare supplement or Medicare cost policy or certificate, the replacing issuer shall waive any time periods applicable to pre−existing condition waiting periods in the new Medicare supplement or new Medicare cost policy to the extent such time was satisfied under the original policy or certificate.

(28) GROUP POLICY CONTINUATION AND CONVERSION REQUIREMENTS. (a) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in par. (c), the issuer shall offer certificateholders at least the following choices:

1. An individual Medicare supplement policy which provides for continuation of the benefits contained in the group policy; and

2. An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards in sub. (5) (c).

(b) If membership in a group is terminated, the issuer shall:

1. Offer the certificateholder such conversion opportunities as are described in par. (a); or

2. At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy for the time specified in s. 632.897, Stats.

(c) If a group Medicare supplement policy is replaced by another group Medicare supplement policy, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any limitation for pre−existing conditions that would have been covered under the group policy being replaced.

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

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

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

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(30) MEDICARE SELECT POLICIES AND CERTIFICATES. (a) 1. This subsection shall apply to Medicare select policies and certificates issued prior to June 1, 2010.

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

(b) For the purposes of this subsection:

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

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

3. "Medicare select issuer" means an issuer offering, or seeking to offer, a Medicare select policy or certificate.

4. "Medicare select policy" or "Medicare select certificate"mean, respectively, a Medicare supplement policy or certificate that contains restricted network provisions.

5. "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare select policy.

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

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

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

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

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

1. Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

a. Such services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after−hour care. The hours of operation and availability of after−hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual medical travel times within the community.

b. The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either to deliver adequately all services that are subject to a restricted network provision or to make appropriate referrals.

c. There are written agreements with network providers describing specific responsibilities.

d. Emergency care is available 24 hours per day and 7 days per week.

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

2. A statement or map providing a clear description of the service area.

3. A description of the grievance procedure to be utilized.

4. A description of the quality assurance program, including:

a. The formal organizational structure;

b. The written criteria for selection, retention and removal of network providers; and

c. The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

5. A list and description, by specialty, of the network providers.

6. Copies of the written information proposed to be used by the issuer to comply with par. (i).

7. Any other information requested by the commissioner.

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

2. An updated list of network providers shall be filed with the commissioner at least quarterly.

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

1. The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and

2. It is not reasonable to obtain such services through a network provider.

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

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

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

a. Other Medicare supplement policies or certificates offered by the issuer; and

b. Other Medicare select policies or certificates.

2. A description, including address, phone number and hours of operation, of the network providers, including primary care physicians, specialty physicians, hospitals and other providers.

3. A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out−of−network providers do not count toward the out−of−pocket annual limit contained in the Medicare Select 50% and 25% Coverage Cost−Sharing plans offered by the Medicare select issuer pursuant to pars. (q) and (r).

4. A description of coverage for emergency and urgently needed care and other out of service area coverage.

5. A description of limitations on referrals to restricted network providers and to other providers.

6. A description of the policyholder's or certificateholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.

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

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8. A designation: MEDICARE SELECT POLICY. This designation shall be immediately below and in the same type size as the designation required in sub. (5) (a) or (7) (b) 1.

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

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

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

1. The grievance procedure shall be described in the policy and certificate and in the outline of coverage.

2. At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

3. Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision−makers who have authority to fully investigate the issue and take corrective action.

4. If a grievance is found to be valid, corrective action shall be taken promptly.

5. All concerned parties shall be notified about the results of a grievance.

6. The issuer shall report no later than each March 31st to the commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

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

(m) 1. At the request of an individual insured under a Medicare select policy or certificate, a Medicare select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer, which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies or certificates available without requiring evidence of insurability after the Medicare select policy or certificate has been in force for 6 months.

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

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

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

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

(o) A Medicare select issuer shall comply with reasonable requests for data made by state or federal agencies, including the CMS, for the purpose of evaluating the Medicare select program.

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

1. The "basic Medicare supplement coverage" as described in sub. (5) (c).

2. Coverage for the Medicare Part A hospital deductible as described in sub. (5) (i) 1.

3. Coverage for home health care for an aggregate of 365 visits per policy year as described in sub. (5) (i) 2.

4. Coverage for the Medicare Part B medical deductible as described in sub. (5) (i) 3.

5. Coverage for the difference between Medicare Part B eligible charges and the actual charges for authorized referral services. This coverage shall not be described with words or terms that would lead insureds to believe the coverage is for Medicare part B Excess Charges as described in sub. (5) (i) 4.

6. Coverage for benefits obtained outside of the United States as described in sub. (5) (i) 5.

7. Coverage for preventive health care services as described in sub. (5) (c) 14.

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

(q) The Medicare Select 50% Cost−Sharing plans shall only contain the following:

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

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

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

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

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

6. Skilled Nursing Facility Care: Coverage for 50% of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post−hospital

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skilled nursing facility care eligible under Medicare Part A until the out−of−pocket limitation is met as described in subd. 12.;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(30m) MEDICARE SELECT POLICIES AND CERTIFICATES. (a) 1. This subsection shall apply to Medicare select policies and certificates issued on or after June 1, 2010.

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

(b) For the purposes of this subsection:

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

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

3. "Medicare select issuer" means an issuer offering, or seeking to offer, a Medicare select policy or certificate.

4. "Medicare select policy" or "Medicare select certificate" mean, respectively, a Medicare supplement policy or certificate that contains restricted network provisions.

5. "Network provider," means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare select policy or certificate.

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

7. "Service area" means the geographic area approved by the commissioner within which an issuer is authorized to offer a Medicare select policy or certificate.

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

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

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

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1. Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

a. Such services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after−hour care. The hours of operation and availability of after−hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual medical travel times within the community.

b. The number of network providers in the service area is sufficient, with respect to current and expected policyholders or certificateholders, either to deliver adequately all services that are subject to a restricted network provision or to make appropriate referrals.

c. There are written agreements with network providers describing specific responsibilities.

d. Emergency care is available 24 hours per day and 7 days per week.

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

2. A statement or map providing a clear description of the service area.

3. A description of the grievance procedure to be utilized.

4. A description of the quality assurance program, including all of the following:

a. The formal organizational structure.

b. The written criteria for selection, retention and removal of network providers.

c. The procedures for evaluating quality of care provided by network providers.

d. The process to initiate corrective action when warranted.

5. A list and description, by specialty, of the network providers.

6. Copies of the written information proposed to be used by the issuer to comply with par. (i).

7. Any other information requested by the commissioner.

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

2. An updated list of network providers shall be filed with the commissioner at least quarterly.

(g) A Medicare select policy or certificate may not restrict payment for covered services provided by non−network providers if both of the following occur:

1. The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition.

2. It is not reasonable to obtain such services through a network provider.

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

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

1. An outline of coverage in substantially the same format as Appendices 2 and 5 sufficient to permit the applicant to compare the coverage and premiums of the Medicare select policy or certificate to the following:

a. Other Medicare supplement policies or certificates offered by the issuer.

b. Other Medicare select policies or certificates.

2. A description, including address, phone number and hours of operation, of the network providers, including primary care physicians, specialty physicians, hospitals and other providers.

3. A description of the restricted network provisions, including payments for copayments or coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out−of−network providers do not count toward the out−of−pocket annual limit contained in the Medicare Select 50% and 25% Coverage Cost−Sharing plans offered by the Medicare select issuer pursuant to pars. (r) and (s).

4. A description of coverage for emergency and urgently needed care and other out of service area coverage.

5. A description of limitations on referrals to restricted network providers and to other providers.

6. A description of the policyholder's or certificateholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.

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

8. A designation: MEDICARE SELECT POLICY. This designation shall be immediately below and in the same type size as the designation required in sub. (4s) (a) 10.

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

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

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

1. The grievance procedure shall be described in the policy and certificate and in the outline of coverage.

2. At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder or certificateholder describing how a grievance may be registered with the issuer.

3. Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision−makers who have authority to fully investigate the issue and take corrective action.

4. If a grievance is found to be valid, corrective action shall be taken promptly.

5. All concerned parties shall be notified about the results of a grievance.

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6. The issuer shall report to the commissioner no later than each March 31st regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

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

(m) 1. At the request of an individual insured under a Medicare select policy or certificate, a Medicare select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer, which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies or certificates available without requiring evidence of insurability after the Medicare select policy or certificate has been in force for 6 months.

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

(n) Medicare select policies and certificates shall provide for continuation of coverage in the event the Secretary determines that Medicare select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare select program to be reauthorized under law or its substantial amendment, then the following apply:

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

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

(o) A Medicare select issuer shall comply with reasonable requests for data made by state or federal agencies, including the CMS, for the purpose of evaluating the Medicare select program.

(p) Except as provided in par. (r) or (s), a Medicare select policy or certificate shall contain the following coverages:

1. The "basic Medicare supplement coverage" as described in sub. (5m) (d).

2. Coverage for 100% of the Medicare Part A hospital deductible as described in sub. (5m) (e) 1.

3. Coverage for home health care for an aggregate of 365 visits per policy or certificate year as described in sub. (5m) (e) 3.

4. Coverage for 100% of the Medicare Part B medical deductible as described in sub. (5m) (e) 4.

5. Coverage for preventive health care services as described in sub. (5m) (d) 15.

6. Coverage for emergency care obtained outside of the United States as described in sub. (5m) (e) 7.

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

1. Coverage for 50% of the Medicare Part A hospital deductible with no out−of−pocket maximum as described in sub. (5m) (e) 2.

2. Coverage for 100% of the Medicare Part B medical deductible subject to copayment or coinsurance as described in sub. (5m) (e) 5.

(r) The Medicare Select 50% Cost−Sharing plans issued with an effective date on or after June 1, 2010, shall only contain the following coverages:

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

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

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

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

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

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

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

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

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

10. Coverage for 100% of the cost sharing for the benefits described in sub. (5m) (d) 1., 6., 7., 9., 14., 16., and 17., and (e) 3., to the extent the benefits do not duplicate benefits paid by Medicare and after the policyholder or certificateholder pays the Medicare Part A and B deductible and meets the out−of−pocket limitation described in subd. 12.

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

12. Coverage for 100% of all cost sharing under Medicare Part A or B for the balance of the calendar year after the individual has reached the out−of−pocket limitation on annual expenditures under Medicare Parts A and B of [$4,440] in 2010, indexed each year by the appropriate inflation adjustment specified by the Secretary.

(s) The Medicare Select 25% Coverage Cost−Sharing plans issued with an effective date on or after June 1, 2010, shall only contain the following coverages:

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

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

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

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

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

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

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

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

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

10. Coverage for 100% of the cost sharing for the benefits described in sub. (5m) (d) 1., 6., 7., 9., 14., 16., and 17., and (e) 3., to the extent the benefits do not duplicate benefits paid by Medicare and after the policyholder or certificateholder pays the Medicare Part A and B deductible and meets the out−of−pocket limitation described in subd. 12.

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

12. Coverage for 100% of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out−of−pocket limitation on annual expenditures under Medicare Parts A and B of [$2,220] in 2010, indexed each year by the appropriate inflation adjustment specified by the Secretary.

(t) A Medicare select policy or certificate may include permissible additional coverage as described in sub. (5m) (e) 2., 5., and 7. These riders, if offered, shall be added to the policy or certificate as separate riders or amendments and shall be priced separately and available for purchase separately.

(u) Issuers writing Medicare select policies or certificates shall additionally comply with subchs. I and III of ch. Ins 9.

(31) REFUND OR CREDIT CALCULATION. (a) An issuer shall collect and file with the commissioner by May 31 of each year the data contained in the applicable reporting form contained in Appendix 8 for each type of policy or certificate form as described in sub. (14), including policies and certificates under sub. (14) (L) that are renewed after December 31, 1995.

(b) If, on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type of policy form as described in sub. (14). For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

(bm) For the purposes of this section, for policies or certificates issued prior to January 1, 1992, the issuer shall make the refund or credit calculation separately for all individual policies combined and all group policies combined for experience after January 1, 1996. The first such report shall be due by May 31, 1998.

(c) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds $5.00. Such refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary of health and human services, but in no event shall it be less than the average rate of interest for 13−week U.S. treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

(32) PUBLIC HEARINGS. The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of this section if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for such reporting period. Public notice of such hearing shall be furnished in a manner deemed appropriate by the commissioner.

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

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

(b) *Eligible persons.* An eligible person is an individual described in any of the following subdivisions:

1. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare and the plan does any of the following:

a. Terminates.

b. Ceases to provide some or all such supplemental health benefits to the individual.

c. The amount the individual pays for coverage under the plan increases from one 12−month period to the subsequent 12−month period by more than 25% and the new payment for the employer−sponsored coverage is greater than the premium charged under the Medicare supplement plan for which the individual is applying. An issuer may require reasonable documentation to substantiate the increase of the cost of coverage to the individual. Reasonable documentation that issuers may request includes premium billing statements and notices of premiums from employers for the most recent 12 month period.

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

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

1s. The individual is enrolled in a Medicare select plan and is notified by the issuer as required in par. (f) 3. and s. Ins 9.35, as applicable, that a hospital is leaving the Medicare select network and that there is no other participating hospital within a 30 minute or 30 mile radius of the policyholder.

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

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

b. The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides.

c. The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary, but not including termination of the individual's enrollment on the basis described in section 1851 (g) (3) (B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area.

d. The individual demonstrates, in accordance with guidelines established by the secretary that, at least one of the following has occurred; the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards, or the organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual.

e. The individual meets such other exceptional conditions as the secretary may provide.

3. The individual is enrolled with any of the following:

a. An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost);

b. A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

c. An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or

d. An organization under a Medicare select policy; and

3m. The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under subd. 2.

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

a. Of the insolvency of the issuer or bankruptcy of the nonissuer organization or of other involuntary termination of coverage or enrollment under the policy;

b. The issuer of the policy substantially violated a material provision of the policy; or

c. The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

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

b. The subsequent enrollment under subd. 5. a. is terminated by the enrollee during any period within the first 12 months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the federal Social Security Act); or

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

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

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

(c) *Guaranteed issue time periods*. 1. In the case of an individual described in par. (b) 1., 1m., or 1s., the guaranteed issue period begins on the later of the following dates:

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

b. The date the individual receives notice that a claim has been denied because of such a termination or cessation, if the individual did not receive notice of the plan's termination or cessation, and ends 63 days after the date of notice of the claim denial.

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

3. In the case of an individual described in par. (b) 4. a., the guaranteed issue period begins on the earlier of either: the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice, if any; or the date that the applicable coverage is terminated. The guaranteed issue period ends on the date that is 63 days after the date such coverage is terminated.

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

5. In the case of an individual described in par. (b) 7., the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882 (v) (2) (B) of the Social Security

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Act from the Medicare supplement issuer during the 60−day period immediately preceding the initial Medicare Part D enrollment period and ends on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D.

6. In the case of an individual described in par. (b) but not described in the preceding provisions of this paragraph, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date.

(d) *Extended Medigap access for interrupted trial periods.* 1. In the case of an individual described in par. (b) 5., or deemed to be so described pursuant to this subdivision, whose enrollment with an organization or provider described in par. (b) 5. a. is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in par. (b) 5.

2. In the case of an individual described in par. (b) 6., or deemed to be so described pursuant to this paragraph, whose enrollment with a plan or in a program described in par. (b) 6. is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in par. (b) 6.

3. For purposes of par. (b) 5. and 6., no enrollment of an individual with an organization or provider described in par. (b) 5. a., or with a plan or in a program described in par. (b) 6., may be deemed to be an initial enrollment under this paragraph after the 2−year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

(e) *Products to which eligible persons are entitled prior to June 1, 2010.* The Medicare supplement or Medicare cost policy to which eligible persons are entitled under:

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

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

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

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

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

6. The Outpatient Prescription Drug Rider referenced in sub. (5) (i) 7. may only be issued through December 31, 2005.

(ez) *Products to which eligible persons are entitled on or after June 1, 2010.* The Medicare supplement or Medicare cost policy or certificate to which eligible persons are entitled under:

1. Paragraph (b) 1., 1m., 1r., 1s., 2., 3. and 4., is a Medicare supplement policy or certificate as defined in sub. (5m) along with any riders available or a Medicare select policy or certificate as defined in sub. (30m).

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

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

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

(f) *Notification provisions.* 1. At the time of an event described in par. (b) because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement or Medicare cost policies under par. (a). The notice shall be communicated contemporaneously with the notification of termination.

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

3. At the time of an event described in par. (b) because of which a hospital in a Medicare select network leaves the network the issuer shall notify the insured of his or her rights under this section, and of the obligations of issuers of Medicare supplement or Medicare cost policies under par. (a). The notice to insureds shall be communicated within 10 business days of the issuer receiving notification of the hospital's notice of leaving the network.

(35) EXCHANGE OF MEDICARE SUPPLEMENT POLICY. An issuer that submits and receives approval to offer a Medicare supplement insurance policy that is effective or issued on or after June 1, 2010, may offer an exchange subject to the following requirements:

(a) By or before May 31, 2011, on a one−time basis in writing, an issuer may offer to all of its existing Medicare supplement policyholders or certificateholders covered by a policy with an effective prior to June 1, 2010, the option to exchange the existing policy to a different policy that complies with subs. (4s), (5m) and (30m), as applicable.

(b) The offer shall be made on a nondiscriminatory basis without regard to the age or health status of the insured unless such offer or issue would be in violation of state or federal law.

(c) The offer shall remain open for a minimum of 120 days from the date of the mailing by the issuer.

(d) In the event of an exchange, if the replaced policy is priced on an issue age rate schedule, the rate charged to the insured for the newly exchanged policy shall recognize the policy reserve buildup, due to the pre−funding inherent in the use of an issue age rate basis, for the benefit of the insured.

(e) The rating class of the new policy or certificate shall be the class closest to the insured's class of the replaced coverage.

(f) The issuer may not apply new preexisting condition limitations or a new incontestability period to the newly issued policy for those benefits that were contained in the exchanged policy or certificate of the insured but may apply a preexisting condition limitation of no more than 6 months to any added benefits contained in the newly issued policy or certificate that were not present in the exchanged policy or certificate.

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(36) GENETIC INFORMATION. In addition to compliance with ss. 631.89 and 632.748, Stats., beginning on May 21, 2009, an issuer of a Medicare supplement policy or certificate may not deny or condition the issuance or effectiveness of the policy or certificate, including the imposition of any exclusion of benefits under the policy based on a preexisting condition, on the basis of the genetic information with respect to such individual. The issuer may not discriminate in the pricing of the policy or certificate, including the adjustment of rates of an individual on the basis of the genetic information with respect to such individual.

(a) In this subsection and for use in policies or certificates:

1. "Family member" means, with respect to an individual, any other individual who is a first through fourth degree relative of the individual.

2. "Genetic information" means, with respect to any individual, information about such individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research that includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term "genetic information" does not include information about the sex or age of any individual.

3. "Genetic services" means a genetic test, genetic counseling including, obtaining, interpreting, or assessing genetic information, or genetic education.

4. "Genetic test" means an analysis of human deoxyribonucleic acid, ribonucleic acid or chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutation, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

5. "Issuer of a Medicare supplement policy or certificate" includes third−party administrators, or other person acting for or on behalf of such issuer.

6. "Underwriting purposes," means all of the following:

a. Rules for, or determinations of, eligibility including enrollment and continued eligibility for benefits under the policy.

b. The computation of premium or contribution amounts under the policy.

c. The application of any preexisting condition exclusions under the policy.

d. Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

(b) An issuer of a Medicare supplement policy or certificate may not request or require an individual or a family member of such individual to undergo a genetic test. An issuer may not request, require or purchase genetic information for use in underwriting. An issuer may not request, require or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.

(c) Nothing in par. (b) shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from any of the following;

1. Denying or conditioning the issuance or effectiveness of a policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant.

2. Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy.

(d) Notwithstanding par. (b), the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members to further increase the premium for the group.

(e) An issuer of a Medicare supplement policy or certificate may not request or require an individual or a family member of such individual to undergo a genetic test. Nothing in this paragraph shall be construed to preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a payment determination when consistent with the requirements of par. (b). If genetic information is obtained, the request may only include the minimum amount necessary to accomplish the intended purpose.

(f) If an issuer of a Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring or purchasing of other information concerning any individual, such request, requirement or purchase may not be considered a violation of this section.

Note: This rule requires the use of a rate change transmittal form which may be obtained from the Office of the Commissioner of Insurance, P.O. Box 7873, Madison, WI 53707−7873.

Note: The rule revisions published in June, 1994 first apply to any policy issued, renewed or solicited on or after September 1, 1994.

History: Cr. Register, July, 1977, No. 259, eff. 11−29−77; am. (13), Register, September, 1977, No. 261, eff. 1−1−78; am. (2), (3) (d), (4) (a) 1., (4) (b) 1. a., 3. e. and 4., (5) (a) 3. a., (5) (b) 3. intro., 3. a., 3. b., (5) (c) 3. a. and b., (5) (d) 3. a., (5) (e) 3. intro. and a., r. and recr. (4) (b) 5., (6), (7), (8) and (9), r. (10), renum. (11) to (13) to be (10) to (12), cr. (4) (b) 6. and 7., Register, December, 1978, No. 276, eff. 1−1−79; am. (4) (b) 1.a., (5) (a) 2. and (b) 2., (5) (c) 2. and (9), r. (5) (d) and (e), Register, April, 1981, No. 304, eff. 5−1−81; r. and recr. (7) (b), Register, May, 1981, No. 305, eff. 6−1−81; r. and recr. Register, June, 1982, No. 318, eff. 7−1−82; renum. (4) (a) 9. to be 10., cr. (4) (a) 9., am. (5) (intro.) and (6) (a) 6., Register, October, 1984, No. 346, eff. 11−1−84; r. (12) under s. 13.93 (2m) (b) 16., Stats., Register, December, 1984, No. 348; am. (1) (a) to (c), (2) (a) (intro.), 1. and 2., (3) (b) and (d), (4) (intro.), (a) 5., 8. and 9., (c) 5., (5) (intro.), (a) 2., (b) 2. and (c) 2., (6) (a) 2. and 3., (9), (11) and Appendix, cr. (3) (dm), (5) (d) and (6) (e), r. (13), Register, November, 1985, No. 359, eff. 1−1−86; cr. (5) (a) 3. i., (b) 3. f., (c) 3. e. and (d) 3. g. Register, April, 1987, No. 376, eff. 6−1−87; emerg. r. and recr. eff. 9−30−88; r. and recr. Register, February, 1989, No. 398, eff. 3−1−89; emerg. r. (5) (d) to (h), (8) (d), renum. (3) (a) to be (3) (am), am. (2) (a) 3., (4) (a) 3. and 7., (b) 5., (d), (e) 1. and 5., (g), (5) (c) (intro.), 4. and 5., (i) 4. and 5., (6) (intro.) and (b), (7) (c) 4. and 5., (8) (a) 1. and (e), (9) (e), (10) (a) (intro.) and (d) 2., (11) and (14), r. and recr. (4) (b) 7., and Appendix, cr. (3) (a), (4) (a) 14. and (f), (5) (c) 6. to 10. and (i) 7., (7) (c) 6. to 8. and (d), (15) and (16), Appendix 2 and 3, eff. 12−11−89, except Appendices eff. 1−1−90; emerg. cr. (17) to (19) and am. (5) (c) 4., eff. 1−2−90; r. (5) (d) to (h) and (8) (d), renum. (3) (a) to be (3) (am), am. (2) (a) 3., (4) (a) 2., 3. and 7., (b) 5., (d), (e) 1. and 5., (g) (5) (b), (c) (intro.), 2., 4. and 5., (i) 4. and 5., (6) (intro.) and (b), (7) (c) 4. and 5., (8) (a) 1. and (e), (9) (e), (10) (a) (intro.) and (d) 2., (11) and (14), r. and recr. (4) (b) 7. and Appendices, cr. (3) (a), (4) (a) 14. and (f), (5) (c) 6. to 12. and (i) 7., (7) (c) 6. to 8. and (d), (15) to (28), Appendices 2 to 6, Register, July, 1990, No. 415, eff. 8−1−90; emerg. cr. (3) (af) to (aj), (bl), (gl), (gm), (il), (im), (14) (a), (16) (d) and (29), r. and recr. (3) (c), am. (3) (d), (4) (a) 3. and 5., (e), (5) (c) 2., (7) (c) 3., (8) (a) 3., (16) (a) and (b), (21) (a) to (c), (23) (c) and (d), renum. (14) (intro.) to be (14) (b), eff. 1−1−91; r. (9) (b), Register, April, 1991, No. 424, eff. 6−1−91; cr. (3) (af) to (ai), (bl), (gl), (gm), (il) and (im), (4) (a) 15 and (e) 2., (4m), (5) (c) 13., (7) (a) and (b) 3. h. and i, (8) (a) 5, (14) (a) and (b), (16) (d), (24) (f), (25) (c) and (29), am. (3) (d), (4) (a) 3., 5. and 7., (4) (e) (intro.) and (f), (5) (c) (intro.), 2 and 4, (5) (i) (intro.), 1 to 5 and 7, (8) (a) 3. and (b), (11), (16) (a) and (b), (21) (a) to (c), (23) (c), (24) (a) (intro.) and (d), (26) (a) (intro.) and (28) (a) (intro.) and (c), r. and recr. (3) (c), (5) (c) 8. and Appendix 1, renum. (4) (e) 5. to be (4) (e) 3, (7) (intro.) to be (7) (b) (intro.) and am., (7) (a), (b) and (c) (intro.) and 1 to 7 to be (7) (b) 1., 2., and 3. (intro.) and a to g, and am. (7) (b) 3. c. and d, (7) (d) to be (7) (c) and am., (14) to be (14) (c) and (27) (a) to be (27), r. (4) (e) 2. to 4. and (7) (c) 8., Register, July, 1991, No. 427, eff. 8−1−91; emerg. r. (3) (ai), (bl), (gl), (gm) and (il), (4) (f), (17) to (20), (24) (d), renum. (5) (i) 6. to (5) (c) 14., am. (1) (a). (3) (ag), (ah), (im), (4) (intro.), (a) 1., 3., 5., 10., 14., and 18.b., (b) 4., 5. and 7. and (c) 3., (e), (g) 2., (4m), (5) (i) (intro.), 5. and 7., (8) (a) (intro.), (a) 1. and (c), (11), (16), (22) (a) to (f), (23) (a), (c) and(d), (26) (b), (27), Appendix 1 and 5, r. and recr. (14) (c), (29), Appendix 6, cr. (2) (a) 5., (3) (aj), (al), (bm), (ij) and (ik), (4) (a) 16. to 18., (h), (5) (j), (14) (d) to (j), (23) (bl), (24) (g), (30), (33), Appendix 7, eff. 1−1−92; am. (1) (a), (2) (intro.), (a) 3., (3) (ag), (ah), (im), (4) (intro.),(a) 1., 3., 5., 10., and 14., (b) 4., 5., and 7., (c), 3., (e), (g) 2., (4m), (5) (i) (intro.), 5. and 7., (6) (intro.), (8) (a) (intro.), (a) 1. and (c), (11), (16), (22), (a), (b), (d) to (f), (23) (a), (c) and (d), (26) (b), (27), Appendix 1,4 and 5, r. (3) (ai), (bl), (gl), (gm), and (il), (4) (f), (17) to (20) and (22) (c), (24) (d), cr. (2) (a) 5., (3) (aj), (al), (bm), (ij) and (ik), (4) (a) 16. to 18r. (h), (14) (d) to (j), (23) (bl), (24) (g), (30) to (33), and Appendix 7, renum. (5) (i) 6. to be (5) (c) 14., r. and recr. (14) (c) and (29), (7) (d) renum. from Ins 3.13 (2) (jm), Register,

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July, 1992, No. 439, eff. 8−1−92; r. (2) (d) 2., am. (3) (al) (intro.), (4) (a) 1., 5., 7., 15., 16. and 18., (4) (b) 1., (4m) (a) (intro.), (5) (c) 5., 6., 8. and 13., (5) (i) (intro.), 5., (6) (intro.), (7) (a), (7) (b) 3. e., f., h. and i., (7) (c), (7) (d) 2., (8) (b) (10) (a) (intro.), (b) (intro.), (c) (intro.) and (d) 1., (11), (14) (a), (b), (i) and (j), (15), (16) (c) (intro.) and 1., (21) (a) and (c), (22) (b), (23) (b) to (d), (24) (a) (intro.), (b), (c) 1. and 3., (f), (25) (c), (26) (a) (intro.), (27), (28) (a) (intro.), (b) (intro.) and (c), (30) (c), (i) 1. intro., and (p) 7., Appendix 1 and 6, cr. (5) (c) 15., (7) (b) 3. j., (7) (e), (14) (k) to (m), (23) (e), (30) (i) 9. and (30) (p) 8., Register, June, 1994, No. 462, eff. 9−1−94; correction in (20) (d) made under s. 13.93 (2m) (b) 1., Stats., Register, June, 1994, No. 462; am. (7) (b) 3. d., h., cr. (7) (b) 3. k. and (f), Register, May, 1995, No. 473, eff. 6−1−95; am. (4) (a) 5., 16. and 18., (4m) (a), (5) (b), (7) (a) (intro.), (b) 1. and 2., (q) (c) 2., (d) 2. and (e), (11), (14) (d), (l) and (16) (d) (intro.), (23) (a), (c), (28) (c) and (31) (a), Appendix 1 and 5, cr. (4) (a) 19., (h) 2., (7) (a) 1. and 2., (9) (b), (21) (e), (22) (i) and (31) (bm), Appendix 8, renum. (4) (h) to be (4) (h) 1. and am, r. and recr. Appendix 6, Register, December, 1995, No. 480, eff. 1−1−96; cr. (3) (akm), (aks), (akv), (cm) and (iL), (4m) (c) and (d), (5) (c) 16., 17., (k) and (m), (21) (f), (25) (d) and (34), am. (4m) (a) (intro.), (7) (b) (intro.) to 3. (intro.), (c) and (e), (9) (b) and (30) (i) 9., r. and recr. Appendix 1 and 4, am. Appendix 8, Register, January, 1999, No. 517, eff. 2−1−99; corrections in (4) (b) 7. and (14) (j) made under s. 13.93 (2m) (b) 7., Stats., Register, January, 1999, No. 517; am. (34) (b) 1., 2., 3. b. and 6., cr. (34) (b) 1m., Register, July, 1999, No. 523, eff. 8−1−99; cr. (7) (g) and (30) (r), Register, February, 2000, No. 530, eff. 3−1−00; CR 00−133: am (2) (a) (intro.), (3) (cm), (4) (intro.), (a), (b) 2., (34) (b) 5. a., 6., (c) 1. and Appendix 1, cr. (4) (a) 18p., (34) (b) 2. b., 2. f. and (c) 3., r. (7) (b),(c), (7) (g), (21) (f), r. and recr. (7) (d), (13) and (34) (b) 2.a., renum (7) (e) to be (7) (c) and am., renum. (7) (f) to be (7) (d), (34) (b) 2. b. to be 2. c., 2. c. to be 2. d and 2. d. to be 2. e.,Register October 2001 No. 550, eff. 11−1−01; corrections in (34) (b) 2. and 3., made under s. 13.93 (2m) (b) 1., Stats., Register October 2001 No. 550; emerg. am. eff. 12−16−02; corrections in (2) (a), (4), (7) (b) and (c), (13) and (33) made under s. 13.93 (2m) (b) 7., Stats., Register December 2002 No. 564; CR 02−118: am. (4) (a) 18p., (5) (c) 4., (34) (a) 1. and 2., (b) (intro.), 2. (intro.), a., b., 3. (intro.), a. and c., 4. (intro.), 5. a. and 6., r. (34) (b) 2. f. and fm., renum. (34) (c) and (d) to be (34) (e) and (f), cr. (34) (c) and (d) Register April 2003 No. 568, eff. 5−1−03; CR 04−121: am. (1) (c), (4) (intro.), (a) 1. to 3., 6., 12., 18m. and 18r. b., (4m) (a), (b) and (d), (5) (c) 6., 12. to 15., (i) (intro.) and 7., (j), (k) (intro.), (m) (intro.), (14) (a), (c) 6., (j), (m), (15), (16) (a), (c) (intro.), 1., 3. and (e), (21) (a) and (e), (22) (a), (b), (d), (e), (f) (intro.) and 1., (23) (a) (intro.), 1., 3., 4. and (c), (25) (a) to (c), (26) (a) (intro.), (27), (29), (30) (a), (b) 1. to 7., (c), (d), (e) (intro.) and 1. e., (f) 1., (g) (intro.), (h), (i) (intro.), 1. (intro.) and b., 3., 7., and 9., (j), (k) (intro.), (L) to (o), (p) (intro.) and 8., (34) (a), (b) 1., 1m., 2. (intro.) and a., 3. d., 4. (intro.), 5. a., 6., (c) 1. (intro.) and a., 2., 4., (e) and (f), and Appendices 5 and 8, cr. (2) (f), (4) (a) 20., 21., (5) (n), (o), (23) (a) 5., (30) (q), (r), (34) (b) 1r., 7., 8., and (c) 5., r. and recr. (3), (7), (22) (i) and Appendices 1, 3, 4, and 6, renum. (23) (a) 5., (30) (q) and (r) and (34) (c) 5. to be (23) (a) 6, (30) (s) and (t) and (34) (c) 6. and am. (23) (a) 6., (30) (s) and (t), r. (33) Register June 2005 No. 594, eff. 7−1−05; CR 08−112: am. (1) (a), (b), (3) (q), (v), (w), (4) (intro.), (a) 3., 8., 17., (5) (title), (intro.), (6) (intro.), (7) (a), (d), (8) (c), (9) (b), (14) (title), (a), (d) 3., (15), (23) (d), (24) (g), (26) (b), (30) (a) 1., 2., (b) (intro.), (31) (a) and (34) (e) (title), renum. (1) (c) to be (1) (d), cr. (1) (c), (3) (ce), (cs), (4s), (5m), (14m), (17), (18), (30m), (34) (ez), (35) and (36) Register June 2009 No. 642, eff. 7−1−09; CR 09−076: am. (5m) (e) (intro.), 5., (6) (intro.), (7) (a) (intro.), (8) (a) (intro.), (14m) (d) (intro.), (34) (b) 1., (c) 1., (ez) 1. and Appendix 3, cr. (5m) (k), (7) (cm), (dm), (30m) (p) 6., (34) (b) 1. c., 1s. and (f) 3., r. (30m) (q) 1., renum. (30m) (q) 2. and 3. to be (30m) (q) 1. and 2. Register May 2010 No. 653, eff. 6−1−10; correction in (7) (cm) made under s. 13.93 (2m) (b) 7., Stats., Register, May 2010 No. 653.

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Ins 3.39 APPENDIX 1

For policies with an effective date prior to June 1, 2010 the following information shall be inserted prior to each outline of coverage provided to an insured and include the information specific to the plan type.

PREMIUM INFORMATION

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

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

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

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

POLICY REPLACEMENT

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

NOTICE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) Outpatient prescription drugs.

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

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

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

(h) Waiting period for pre–existing conditions.

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

(j) Usual, customary, and reasonable limitations.

(6) CONSPICUOUS STATEMENTS AS FOLLOWS:

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare & You" for more details.

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

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

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

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

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

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MEDICARE SUPPLEMENT AND MEDICARE COST PREMIUM INFORMATION
Annual Premium
$ ( ) BASIC MEDICARE SUPPLEMENT OR MEDICARE COST COVERAGE

OPTIONAL BENEFITS FOR MEDICARE SUPPLEMENT OR MEDICARE COST POLICY

Each of these riders may be purchased separately.

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

$ ( ) 1. Medicare Part A deductible

100% of Medicare Part A deductible

$ ( ) 2. Additional home health care

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

$ ( ) 3. Medicare Part B deductible

100% of Medicare Part B deductible

$ ( ) 4. Medicare Part B excess charges

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

$ ( ) 5. Foreign travel rider

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

_____

$ ( ) TOTAL FOR BASIC POLICY AND SELECTED OPTIONAL BENEFITS

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

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

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

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

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

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

OUTLINE OF COVERAGE − A

(COMPANY NAME)

OUTLINE OF MEDICARE SUPPLEMENT INSURANCE

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

MEDICARE SUPPLEMENT PART A – HOSPITAL SERVICES –
PER BENEFIT PERIOD

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

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

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

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

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

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

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MEDICARE SUPPLEMENT POLICIES − PART B BENEFITS

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

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

MEDICARE PART B BENEFITS	**PER CALENDAR YEAR**	**MEDICARE PAYS**	**[AFTER YOU PAY A $ [ ] DEDUCTIBLE] THIS POLICY PAYS**	**YOU PAY**
MEDICAL EXPENSES. Eligible expense for physician's services, in−patient and out−patient medical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First $[ ] of Medicare approved amounts* Remainder of Medicare approved amounts	$ 0 Generally 80%	$0 or ☐ Optional Part B Deductible Rider** Generally 20% ☐ Optional Medicare Part B Excess Charges Rider**	
BLOOD	First 3 pints Next $[ ] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 $0 80%	All costs [$[ ] (Part B deductible)] 20%	
CLINICAL LABORATORY SERVICES Tests for diagnostic services		100%	$0	
HOME HEALTH CARE		100% of charges for visits considered medically necessary by Medicare	40 visits or ☐ Optional Additional Home Health Care Rider**	
PREVENTIVE MEDICAL CARE BENEFIT – NOT COVERED BY MEDICARE. Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare.	First $120 each calendar year Additional charges	$0 $0	$120 [$0] or $[dollar amount]	

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

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

Removed by Register December 2010 No. 660. For current adm. code see: http://docs.legis.wisconsin.gov/code/admin_code.

OUTLINE OF COVERAGE − B

(COMPANY NAME)

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

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

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

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

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

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

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

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

Removed by Register December 2010 No. 660. For current adm. code see: http://docs.legis.wisconsin.gov/code/admin_code.

MEDICARE COST−SHARING POLICIES − PART B BENEFITS

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

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

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

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

Removed by Register December 2010 No. 660. For current adm. code see: http://docs.legis.wisconsin.gov/code/admin_code.

OUTLINE OF COVERAGE − C
(COMPANY NAME)
OUTLINE OF MEDICARE COST INSURANCE

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

MEDICARE COST PART A – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

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

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

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

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

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

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MEDICARE COST POLICIES − PART B BENEFITS

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

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

MEDICARE PART B BENEFITS	PER CALENDAR YEAR	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
MEDICAL EXPENSES. Eligible expense for physician's services, in−patient and out−patient medical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment	First [$] of Medicare approved amounts* Remainder of Medicare approved amounts	$ 0 Generally 80%	$0 or ☐ Optional Part B Deductible Rider** Generally 20%	
BLOOD	First 3 pints Next $[ ] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 $0 80%	All [$[ ] (Part B deductible)] 20%	
CLINICAL LABORATORY SERVICES Tests for diagnostic services		100%	$0	
HOME HEALTH CARE		100% of charges for visits considered medically necessary by Medicare	40 visits ☐ Optional Additional Home Health Care Rider**	

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

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

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OUTLINE OF COVERAGE − D

(COMPANY NAME)

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

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

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

MEDICARE SELECT PART A – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

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

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

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

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MEDICARE SELECT POLICIES − PART B BENEFITS

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

MEDICARE PART B BENEFITS	**PER CALENDAR YEAR**	**MEDICARE PAYS**	**[AFTER YOU PAY A $[ ] DEDUCTIBLE THIS POLICY PAYS**	**YOU PAY**
MEDICAL EXPENSES In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:	First $[ ] of Medicare approved amounts	$0	[$[ ] (Part B deductible)] or $0	◊
	[Preventive Benefits for Medicare covered services**]	[Generally [ ]% or more of Medicare approved amounts**]	[Remainder of Medicare approved amounts**]	
	Remainder of Medicare approved amounts	Generally 80%	Generally [10% or 15%]	◊
BLOOD	First 3 pints	$0	[ ]%	◊
	Next $ [ ] of Medicare approved amounts*	$0	$0	◊
	Remainder of Medicare approved amounts	Generally 80%	Generally [10% or 15%]	◊
CLINICAL LABORATORY SERVICES Tests for diagnostic services		100%	$0	
[HOME HEALTH CARE]		100% of charges for visits considered medically necessary by Medicare	365 necessary visits for medically necessary services	
[PREVENTIVE MEDICAL CARE BENEFIT − NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare.]*	[First $120 each calendar year]	[$0]	[$120]	
	[Additional charges]**	[$0]**	[$0] or $[dollar amount]**	

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

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

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Ins 3.39 APPENDIX 2

For policies with an effective date on or after June 1, 2010, the following information shall be inserted prior to each outline of coverage provided to an insured and include the information specific to the plan type.

PREMIUM INFORMATION

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

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

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

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

POLICY REPLACEMENT

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

NOTICE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) Outpatient prescription drugs.

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

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

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

(h) Waiting period for pre–existing conditions.

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

(j) Usual, customary, and reasonable limitations.

(5) CONSPICUOUS STATEMENTS AS FOLLOWS:

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare & You" for more details.

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

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

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

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

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

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MEDICARE SUPPLEMENT AND MEDICARE SELECT PREMIUM INFORMATION
Annual Premium
$ ( ) BASIC MEDICARE SUPPLEMENT OR MEDICARE SELECT COVERAGE

OPTIONAL BENEFITS FOR MEDICARE SUPPLEMENT OR MEDICARE SELECT POLICY

Each of these riders may be purchased separately.

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

$ ( ) 1. 100% of the Medicare Part A hospital deductible

$ ( ) 2. 50% of the Medicare Part A hospital deductible per benefit period with no out−of−pocket maximum

$ ( ) 3. Additional home health care

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

$ ( ) 4. 100% of Medicare Part B deductible

$ ( ) 5. 100% of the Medicare Part B medical deductible subject to copayment or coinsurance of no more than $20 per office visit and no more than $50 per emergency room visit in addition to the Medicare Part B deductible and in addition to out−of−pocket maximums. The emergency room copayment or coinsurance fee shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

$ ( ) 6. Medicare Part B excess charges

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

$ ( ) 7. Foreign travel emergency rider

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

_____

$ ( ) TOTAL FOR BASIC POLICY AND SELECTED OPTIONAL BENEFITS

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

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

(11) If premiums for each rating classification are not listed in the outline of coverage under subsection (10), then the issuer shall give a separate schedule of premiums for each rating classification with the outline of coverage.

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

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

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Ins 3.39 APPENDIX 3

OUTLINE OF COVERAGE

(COMPANY NAME)

OUTLINE OF MEDICARE SUPPLEMENT INSURANCE

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

MEDICARE SUPPLEMENT PART A – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

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

Note: This includes the Medicare deductibles for Part A and Part B, but does not include [the plan's separate riders deductible.]

Note: Add the following text in a bold or contrasting color if the plan is a Medicare supplement insurance − high deductible plan as defined at sub. (5m) (k): This high deductible plan offers benefits after one has paid a calendar year [$2000] deductible. This deductible consists of expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	PER BENEFIT PERIOD	MEDICARE PAYS	[AFTER YOU PAY A $[ ] DEDUCTIBLE] THIS POLICY PAYS	YOU PAY
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies.	First 60 days	All but $ [current deductible]	$0 or [☐ OPTIONAL PART A DEDUCTIBLE RIDER* (for non−high deductible plans)] [☐ PART A DEDUCTIBLE RIDER* (for high deductible plans)] ☐ OPTIONAL MEDICARE 50% PART A DEDUCTIBLE RIDER***	
	61st to 90th days	All but $ [current amount] per day	$ [current amount] per day	
	91st day and after while using 60 lifetime reserve days	All but $ [current amount] per day	$ [current amount] per day	
	Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare eligible expenses**	
	Beyond the additional 365 days	$0	$0	
SKILLED NURSING FACILITY CARE You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare−approved facility within 30 days after leaving the hospital	First 20 days	All approved amounts	$0	
	21st through 100th day	All but $ [current amount] per day	Up to $[ ] a day	
	101st day and after	$[0]	$0	

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SERVICES	PER BENEFIT PERIOD	MEDICARE PAYS	[AFTER YOU PAY A $[ ] DEDUCTIBLE] THIS POLICY PAYS	YOU PAY
INPATIENT PSYCHIATRIC CARE Inpatient psychiatric care in a participating psychiatric hospital		190 days per lifetime	175 days per lifetime	
BLOOD	First 3 pints Additional amounts	$0 100%	First 3 pints $0	
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited coinsurance or copayment for outpatient drugs and inpatient respite care	$0 or [ ]% of coinsurance or copayments	

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

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

*** This optional rider may reduce your premium when you pay 50% of Medicare Part A deductible.

MEDICARE SUPPLEMENT POLICIES – PART B BENEFITS

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

Note: Add the following text in a bold or contrasting color if the plan is a Medicare supplement insurance−high deductible plan as defined at sub. (5m) (k): This high deductible plan offers benefits after one has paid a calendar year [$2000] deductible. This deductible consists of expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

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MEDICARE PART B BENEFITS	PER CALENDAR YEAR	MEDICARE PAYS	[AFTER YOU PAY A $[ ] DEDUCTIBLE] THIS POLICY PAYS	YOU PAY
MEDICAL EXPENSES Eligible expense for physician's services, in−patient and out−patient medical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment	First $[ ] of Medicare approved amounts*	$0	$0 or [☐ OPTIONAL PART B DEDUCTIBLE RIDER** (for non−high deductible plans)] [☐ PART B DEDUCTIBLE RIDER**(for high deductible plans)] ☐ OPTIONAL PART B COPAYMENT OR COINSURANCE RIDER***	
	Remainder of Medicare approved amounts	Generally 80%	Generally 20% [☐ OPTIONAL MEDICARE PART B EXCESS CHARGES RIDER** (for non−high deductible plans)] [☐ MEDICARE PART B EXCESS CHARGES RIDER** (for high deductible plans)] [☐ OPTIONAL FOREIGN TRAVEL EMERGENCY RIDER** (non−high deductible plans)] [☐ FOREIGN TRAVEL EMERGENCY RIDER** (for high−deductible plans)]	
BLOOD	First 3 pints	$0	All costs	
	Next $[ ] of Medicare approved amounts*	$0	[$[ ] (Part B deductible)]	
	Remainder of Medicare approved amounts	80%	20%	
CLINICAL LABORATORY SERVICES Tests for diagnostic services		100%	$0	
HOME HEALTH CARE		100% of charges for visits considered medically necessary by Medicare	40 visits or ☐ OPTIONAL ADDITIONAL HOME HEALTH CARE RIDER**	

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MEDICARE PART B BENEFITS	PER CALENDAR YEAR	MEDICARE PAYS	[AFTER YOU PAY A $[ ] DEDUCTIBLE] THIS POLICY PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA	First $250 each calendar year Remainder of charges	[$0]	$250 80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
[PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare.]*	[First $120 each calendar year] [Additional charges]	[$0] [$0]	[$120] [$0] or $[dollar amount]	

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

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

*** This is an optional rider that may decrease your premium when you pay copayments for medical and emergency room visits.

Removed by Register December 2010 No. 660. For current adm. code see: http://docs.legis.wisconsin.gov/code/admin_code.

Ins 3.39 APPENDIX 4

OUTLINE OF COVERAGE

(COMPANY NAME)

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

(The designation required by sub. (5m) (g) 1. and (h) 1.)

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

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

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

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

SERVICES	PER BENEFIT PERIOD	MEDICARE PAYS	[AFTER YOU PAY A $[ ] DEDUCTIBLE] THIS POLICY PAYS	YOU PAY
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies.	First 60 days	All but $ [current deductible]	$[ ] (50% or 75% of Medicare Part A deductible.)	◊
	61st to 90th days	All but $ [current amount] per day	$ [current amount] per day	
	91st day and after while using 60 lifetime reserve days	All but $ [current amount] per day	$ [current amount] per day	
	Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare eligible expenses**	
	Beyond the additional 365 days	$0	$0	
SKILLED NURSING FACILITY CARE You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital	First 20 days	All approved amounts	$0	◊
	21st through 100th day	All but $ [current amount] per day	Up to $[ ] a day	
	101st day and after	$0	$0	
INPATIENT PSYCHIATRIC CARE Inpatient psychiatric care in a participating psychiatric hospital		190 days per lifetime	175 days per lifetime	
BLOOD	First 3 pints	$0	[50% or 75%]	◊
	Additional amounts	100%	$0	
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited coinsurance or copayment for outpatient drugs and inpatient respite care	[50% or 75%] of coinsurance or copayments	◊

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

Removed by Register December 2010 No. 660. For current adm. code see: http://docs.legis.wisconsin.gov/code/admin_code.

MEDICARE COST−SHARING POLICIES – PART B BENEFITS

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

MEDICARE PART B BENEFITS	**PER CALENDAR YEAR**	**MEDICARE PAYS**	**[AFTER YOU PAY A $[ ] DEDUCTIBLE] THIS POLICY PAYS**	**YOU PAY**
MEDICAL EXPENSES Eligible expense for physician's services, in−patient and out−patient medical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment	First $[ ] of Medicare approved amounts*	$0	$0	◊
	Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	
	Remainder of Medicare approved amounts	Generally 80%	Generally [10% or 15%]	◊
BLOOD	First 3 pints	$0	[50% or 75%]	◊
	Next $[ ] of Medicare approved amounts*	$0	$0	◊
	Remainder of Medicare approved amounts	Generally 80%	Generally [10% or 15%]	◊
CLINICAL LABORATORY SERVICES Tests for diagnostic services		100%	$0	
HOME HEALTH CARE		100% of charges for visits considered medically necessary by Medicare	40 visits or ☐ OPTIONAL ADDITIONAL HOME HEALTH CARE RIDER**	
[PREVENTIVE MEDICAL CARE BENEFIT – NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare.]*	[First $120 each calendar year]	[$0]	[$120]	
	[Additional charges]**	[$0]**	[$0] or $[dollar amount]**	

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

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

Removed by Register December 2010 No. 660. For current adm. code see: http://docs.legis.wisconsin.gov/code/admin_code.

Ins 3.39 APPENDIX 5
OUTLINE OF COVERAGE
(COMPANY NAME)
OUTLINE OF MEDICARE SELECT INSURANCE AND MEDICARE SELECT 50% and 25% COST−SHARING PLANS

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

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

MEDICARE SELECT PART A – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

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

SERVICES	PER BENEFIT PERIOD	MEDICARE PAYS	[AFTER YOU PAY A $[ ] DEDUCTIBLE] THIS POLICY PAYS	YOU PAY
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies.	First 60 days	All but $ [current deductible]	$0 or [ ]% of Medicare Part A deductible	◊
	61st to 90th days	All but $ [current amount] per day	$ [current amount] per day	
	91st day and after while using 60 lifetime reserve days	All but $ [current amount] per day	$ [current amount] per day	
	Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare eligible expenses**	
	Beyond the additional 365 days	$0	$0	
SKILLED NURSING FACILITY CARE You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital	First 20 days	All approved amounts	$0	
	21st through 100th day	All but $ [current amount] per day	Up to $[ ] a day	◊
	101st day and after	$0	$0	
INPATIENT PSYCHIATRIC CARE Inpatient psychiatric care in a participating psychiatric hospital		190 days per lifetime	175 days per lifetime	
BLOOD	First 3 pints	$0	[3 pints] or [ ] %	◊
	Additional amounts	100%	$0	
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited coinsurance or copayment for outpatient drugs and inpatient respite care	$0 or [ ]% of coinsurance or copayments	◊

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

Removed by Register December 2010 No. 660. For current adm. code see: http://docs.legis.wisconsin.gov/code/admin_code.

MEDICARE SELECT POLICIES – PART B BENEFITS

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

MEDICARE PART B BENEFITS	**PER CALENDAR YEAR**	**MEDICARE PAYS**	**[AFTER YOU PAY A $[ ] DEDUCTIBLE] THIS POLICY PAYS**	**YOU PAY**
MEDICAL EXPENSES Eligible expense for physician's services, in−patient and out−patient medical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment	First $[ ] of Medicare approved amounts [Preventive Benefits for Medicare covered services**] Remainder of Medicare approved amounts	$0 [Generally [ ]% or more of Medicare approved amounts**] Generally 80%	$0 [Remainder of Medicare approved amounts**] Generally [10% or 15%]	◊ ◊
BLOOD	First 3 pints Next $[ ] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 $0 Generally 80%	[ ]% $0 Generally [10% or 15%]	◊ ◊ ◊
CLINICAL LABORATORY SERVICES Tests for diagnostic services		100%	$0	
HOME HEALTH CARE		100% of charges for visits considered medically necessary by Medicare	365 visits for medically necessary services	
[PREVENTIVE MEDICAL CARE BENEFIT – NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare.]*	[First $120 each calendar year] [Additional charges]**	[$0] [$0]**	[$120] [$0] or $[dollar amount]**	

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

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

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Ins 3.39 APPENDIX 6

[NOTICE OF CHANGE FOR OUTLINE OF COVERAGE]

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

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

PLEASE READ THIS CAREFULLY!

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

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

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SERVICES	**MEDICARE BENEFITS**		**YOUR [MEDICARE SUPPLEMENT OR MEDICARE REPLACEMENT] COVERAGE**	
	In 2____, Medicare Pays Per Benefit Period	**Effective January 1, 2____, Medicare will Pay**	**In 2____, Your Coverage Pays**	**Effective January 1, 2____, Your Coverage will Pay Per Calendar Year**
BLOOD	Pays all costs except payment of deductible (equal to costs for first 3 pints) each calendar year. Part A blood deductible reduced to the extent paid under Part B	$0 for first 3 pints. 100% of additional amounts		
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance or copayment for outpatient drugs and inpatient respite care $0 or [ ]% of coinsurance or copayments	All but very limited coinsurance or copayment for outpatient drugs and inpatient respite care $0 or [ ]% of coinsurance or copayments		◊
MEDICARE PART B SERVICES AND SUPPLIES				
MEDICAL EXPENSES Eligible expense for physician's services, medical services in and out patient, physical and speech therapy, diagnostic tests, and durable medical equipment.	After $[ ] deductible, generally 80% of remainder of Medicare approved amounts	After $[ ] deductible, generally 80% of remainder of Medicare approved amounts		
HOME HEALTH CARE	100% of charges for visits considered medically necessary by Medicare		40 visits	
PREVENTIVE MEDICAL CARE BENEFIT Some annual physical and preventive tests and services administered or ordered by your doctor when NOT covered by Medicare	$0	$0	$120	

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

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

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

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Ins 3.39 APPENDIX 7

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

(Insurance company's name and address)

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

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement, Medicare cost, Medicare select or Medicare Advantage insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

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

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

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

_____Additional benefits.
_____No change in benefits, but lower premiums.
_____Fewer benefits and lower premiums.
_____My plan has prescription drug coverage and I am enrolling in Medicare Part D. _____Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. [optional only for Direct Mailers.]

_____
_____

Other. (please specify)

_____
_____
_____
_____

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

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

3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all requested material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all requested information has been properly reported. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

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

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

_____
(Applicant's Signature)

_____
(Date)

* Signature not required for direct response sales.

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Ins 3.39 APPENDIX 8

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR_____

TYPE[1] _____ SMSBP[2]) _____
For the State of_____ Company Name _____
NAIC Group Code_____ NAIC Company Code _____
Address_____ Person Completing Exhibit _____
Title_____ Telephone Number _____

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

Medicare Supplement Credibility Table

Life Years Exposed Since Inception	Tolerance
10,000+	0.0%
5,000 – 9,999	5.0%
2,500 – 4,999	7.5%
1,000 – 2,4999	10.0%
500 – 999	15.0%
If less than 500, no credibility.	

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

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

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

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

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

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

_____
Signature

_____
Name – Please Type

_____
Title – Please Type

_____
Date

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

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

(a)[3]	(b)[4]	(c)	(d)	(d)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Premium	Factor	(b)x(c)	Cumu-lative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumu-lative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15+[6]		4.175		0.493		8.684		0.725		0.77
Total:			(k):		(l):			(m):	(u):	

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

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

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

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

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

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

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

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Ins 3.39 APPENDIX 9

FORM FOR REPORTING MEDICARE SUPPLEMENT POLICIES

Company Name:

_____

Address:_____

_____

Phone Number:_____

Due March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate Number	Date of Issuance

_____

Signature

_____

Name and Title (please type)

_____

Date

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Ins 3.39 APPENDIX 10

DISCLOSURE STATEMENTS

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

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

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy.

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

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

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

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

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

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

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

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

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

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

Before You Buy This Insurance

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

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

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

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

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

This is not Medicare Supplement Insurance

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

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

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

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

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

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

Removed by Register December 2010 No. 660. For current adm. code see: http://docs.legis.wisconsin.gov/code/admin_code.

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

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

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

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

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

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

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

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

Before You Buy This Insurance

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

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

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

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

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

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare.

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

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

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

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

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

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

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

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

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

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

Before You Buy This Insurance

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

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

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

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

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

This is not Medicare Supplement Insurance

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

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This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

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

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

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

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

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

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

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

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

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

Before You Buy This Insurance

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

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

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

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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 be 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 all group and blanket disability insurance policies subject to s. 631.01 (1), Stats., that provide 24−hour continuous coverage for medical or dental care, treatment or expenses due to either injury or sickness that contain a coordination of benefits provision, an "excess,""anti−duplication," "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 worker's compensation, employer's liability insurance, or individual traditional automobile"fault" contracts. Except as permitted under s. 632.32 (4) (a) 3m., Stats., this section applies to the medical benefits provisions in an automobile"no fault" type or group or group−type "fault" policy. A policy subject to this section may reduce benefits because of Medicare only to the extent permitted by federal law and shall comply with s. 632.755, Stats., when reducing benefits because of coverage by or eligibility for medical assistance.

(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 any of the following:

1. Services, including supplies.
2. Payment for all or a portion of the expenses incurred.
3. A combination of subds. 1. and 2.
4. Indemnification.

(c) "Claim determination period" means the period of time 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" means 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 employee, 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" means 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" means 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.

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(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 subsection may be used.

(c) Notwithstanding the fact that this section uses the term"Plan," 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" contracts; but, as to the traditional automobile "fault" contracts, only the medical benefits written on a group or group−type basis may be included.

(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. 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 that differ from sub. (11).

2. All plans that cover the person are complying plans and, under sub. (11), 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 employee or the employee'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.

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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. No rule in another plan. 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 that covers the person as an employee, member or subscriber are determined before those of the Plan that covers the person as a dependent of an employee, member or subscriber.

3. Dependent child−parents not separated or divorced. Except as stated in subd. 3. 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 subd. 3. 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.

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.

e. If the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' Plans have actual knowledge of those terms, benefits for the dependent child shall be determined according to subd. 3.

5. Active or inactive employee. The benefits of a Plan which covers a person as an employee who is neither laid off or 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 is ignored.

5m. Continuation coverage. If a person has continuation coverage under federal law or s. 632.897 (3) (a), Stats., and is also covered under another Plan, the following shall determine the order of benefits:

a. First, the benefits of a Plan covering the person as an employee, member or subscriber or as a dependent of an employee, member or subscriber.

b. Second, the benefits under the continuation coverage.

5s. If the other Plan does not have the rule described in subd. 5m. and if, as a result, the Plans do not agree on the order of benefits, this subdivision is ignored.

6. Longer or 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.

6m. 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:

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

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

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

6s. 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.

(c) If a dependent is a Medicare beneficiary and if, under the Social Security Act of 1965 as amended, Medicare is secondary to the Plan covering the person as a dependent of an active employee, the federal Medicare regulations shall supersede this subsection.

(12) PAYMENT AS A SECONDARY PLAN. (a) In accordance with order of benefit determination rules under sub. (11), when This Plan is a secondary Plan as to one or more other Plans, the benefits of This Plan may be reduced as provided in par. (b). The other Plan or Plans are referred to as "the other Plans" in par. (b).

(b) 1. The benefits of This Plan shall be reduced when the sum of the following exceeds the allowable expenses in a claim determination period:

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.

2. If subd. 1. applies, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not equal more than the total 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) If the benefits of This Plan are reduced under par. (b), 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 the 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.

(14) RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION. An insurer has the right to decide the facts it needs to apply the

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COB rules. It may get needed facts from or give them to any other organization or person without the consent of the insured but only as needed to apply the provisions of this section. This subsection does not relieve the insurer of the requirements of s. 146.82, Stats. 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) COORDINATION WITH NONCOMPLYING PLANS. Except for expenses covered by worker's compensation, employer's liability insurance, Medicare, medical assistance, or traditional automobile "fault"contracts, a Complying Plan may coordinate its benefits with a Noncomplying Plan that may not be subject to insurance regulation on the following basis:

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

(b) 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.

(c) 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.

(d) The Complying Plan shall advance to or on behalf of the employee, subscriber, or member an amount equal to the difference if the Noncomplying Plan reduces its benefits so that the employee, 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.

(e) 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 employee, 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.

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.

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

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; am. (2), (6) (d) and (f), (18) (b) (intro.) and Appendix A, cr. (11) (b) 4. e., Register, August, 1989, No. 404, eff. 9−1−89; am. (2), (3) (b), (c) and (k), (6) (b) and (c), (7) (b), (11) (b) 2., (12) (a) and (b), (14) and Appendix A, r. (12) (b) (intro.), (c) and (d), (13) (b) to (f), (18) (a) and (20), cr. (11) (b) 5m., and (c), renum. (13) (a) and (18) (b) to be (12) (c) and (18) and am. (12) (c) and (18) (intro.), Register, October, 1991, No. 430, eff. 1−1−92; correction in (11) made under s. 13.93 (2m) (b) 1., Stats., Register, April, 1992, No. 436; reprinted to correct error in (3) (c), Register, September, 1992, No. 441; correction in (2) made under s. 13.92 (4) (b) 7., Stats., Register May 2010 No. 653.

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Ins 3.40 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, that includes continuous 24−hour coverage. 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 are determined before those of the Plan which covers the person as a dependent of an employee, member or subscriber.

(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.

Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' Plans have actual knowledge of those terms, benefits for the dependent child shall be determined according to (III) (B) (ii).

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.

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(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.

Note: If a dependent is a Medicare beneficiary and if, under the Social Security Act of 1965 as amended, Medicare is secondary to the plan covering the person as a dependent of an active employee, the federal Medicare regulations shall supersede this paragraph (iv).

(v) *Continuation coverage.*

a. If a person has continuation coverage under federal or state law and is also covered under another plan, the following shall determine the order of benefits:

i. First, the benefits of a plan covering the person as an employee, member or subscriber or as a dependent of an employee, member or subscriber.

ii. Second, the benefits under the continuation coverage.

b. If the other plan does not have the rule described in subparagraph a., and if, as a result, the plans do not agree on the order of benefits, this paragraph (v) is ignored.

(vi) *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).

(B) *Reduction in This Plan's Benefits.* The benefits of This Plan will be reduced when the sum of the following exceeds the Allowable Expenses in a Claim Determination Period:

(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. Under this provision, 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.

(V) RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION. The [name of insurance company] has the right to decide the facts it needs to apply these COB rules. It may get needed facts from or give them to any other organization or person without the consent of the insured but only as needed to apply these COB rules. Medical records remain confidential as provided by state law. 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.

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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 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 of ch. 632, Stats. This subsection does not apply to a long−term care policy as defined under s. Ins 3.46 (3) (m).

(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; am. (1), Register, April, 1991, No. 424, eff. 6−1−91; EmR0817: emerg. am. (1), eff. 6−3−08; CR 08−032: am. (1) Register October 2008 No. 634, eff. 11−1−08.

Note: CR 08−032 first applies to policies or certificates issued on or after January 1, 2009 or on the first renewal date on or after January 1, 2009, but no later than January 1, 2010 for collectively bargained policies or certificates.

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.

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

(2) The filing procedures of s. Ins 6.05, 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; correction in (2) made under s. 13.93 (2m) (b) 7., Stats., Register, January, 1999, No. 517.

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., Stats., 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., Stats., 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), Stats., (first sentence), 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 3.455 Long−term care, nursing home and home health care policies; loss ratios; rating practices; continuation and conversion, reserves. (1) FINDINGS. (a) The commissioner finds that long−term care policies and life insurance−long−term care coverage are offered and marketed to a population which is particularly susceptible to pressure sales tactics and misleading or fraudulent sales activities. These products are also complex and difficult for most purchasers to analyze and understand.

(b) The purchase of any of these products is an important and significant decision because of the cost and the significance of these insurance products in planning and providing for long−term care. This section and s. Ins 3.46 are adopted to provide adequate protection for Wisconsin insureds and the public.

(2) APPLICABILITY. (a) This section does not apply to an accelerated benefit coverage of a life insurance policy, endorsement or rider as described under s. Ins 3.46 (2).

(b) This section, except for subs. (6) and (8), does not apply to individual long−term care policy or life insurance−long−term care coverage, to a group long−term care policy or life insurance−long−term care coverage or a certificate under the group policy, or to a renewal policy or coverage or certificate, if:

1. The individual long−term care policy or life insurance−long−term care coverage was issued prior to June 1, 1991;

2. The group policy is issued prior to June 1, 1991 and all certificates under the policy are issued prior to June 1, 1991; or

3. The group policy is issued prior to June 1, 1991 and the policy is exempt from s. Ins 3.46 under s. Ins 3.46 (2) (b).

(c) Section Ins 3.46 in effect prior to June 1, 1991 and subs. (6) and (8) apply to those policies, coverages or certificates which qualify for exemption under par. (b).

(3) DEFINITIONS. In this section:

(a) "Basis for continuation of coverage" means a policy provision that maintains coverage under the existing group policy when the coverage would otherwise terminate and that is subject only to the continued timely payment of premium when due. Group policies that restrict provision of benefits and services to, or contain incentives to use certain providers or facilities may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non−managed care plan, including but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

(b) "Basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy, and any group policy that it replaced, for at least 3 months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

(c) "Converted policy" means an individual policy of long−term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy form which conversion is made restricts provision of benefits and services to or contains incentives to use certain providers or facilities, the commissioner, in making a determination as to the substantial equivalency of the benefits, shall take into consideration the differences between managed−care and non−managed−care plans, including but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity. The converted policy offered shall be on a form generally available in the state.

(d) "Exceptional increase" means an increase in premium by an insurer that the commissioner determines is justified under any of the following circumstances:

1. Changes in laws or rules applicable to long−term care coverage in this state.

2. Increased and unexpected utilization that affects the majority of insurers of similar products.

(e) "Guaranteed renewable" has the meaning given in s. Ins 3.46 (3) (f).

(f) "Incidental" means that the value of the long−term care benefits provided is less than 10% of the total value of the benefits provided over the life of the policy measured as of the date of issue.

(g) "Life insurance−long−term care coverage" has the meaning given in s. Ins 3.46 (3) (j).

(h) "Long−term care policy" has the meaning given in s. Ins 3.46 (3) (k).

(i) "Managed−care plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

(j) "Qualified actuary" means a member in good standing of the American academy of actuaries.

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(k) "Similar policy forms" means all of the long–term care, nursing home and home health care insurance policies and certificates offered by an insurer that fall within one of the following categories:

1. Institutional long–term care, nursing home benefits only.

2. Non–institutional long–term care, home health care benefits only.

3. Comprehensive long–term care, nursing home and home health care benefits.

(4) APPLICATION OF THE INSURANCE CODE TO LONG–TERM CARE, NURSING HOME AND HOME HEALTH CARE GROUP POLICIES. A group or blanket long–term care policy or certificate may be exempt, under s. 600.01 (1) (b) 3., Stats., from chs. 600 to 646, Stats., and rules adopted under those statutes only if:

(a) The policy is issued for delivery and delivered in another state;

(b) The policy is subject to regulatory requirements substantially similar to those provided under chs. 600 to 646, Stats., and the rules;

(c) The policy is otherwise exempt under s. 600.01 (1) (b) 3., Stats.;

(d) The policy and sufficient information to enable the office to determine compliance with pars. (a) to (c) is filed with the office; and

(e) The office makes a written determination that the policy complies with pars. (a) to (c) and that the policy is not contrary to the public interest, before the policy or certificates under the policy are marketed or solicited in this state.

(5) LOSS RATIO REQUIREMENTS. (a) Insurers shall set and maintain rates and benefits for long–term care policies so that the loss ratio is at least:

1. 65%, for individual policies.

2. 65%, for group policies which issue coverage as the result of solicitation of individuals through the mail or the mass media, including, but not limited to, print or broadcast advertising.

3. 75%, for group policies other than those subject to subd. 2.

(b) For the purpose of this subsection a loss ratio shall be calculated on the basis of the ratio of the present value of the expected benefits to the present value of the expected premium over the entire period of coverage. An insurer shall consider and evaluate the following:

1. Statistical credibility of incurred claims experience and earned premium over the entire period of coverage;

2. The entire period for which rates have been computed to provide coverage;

3. Experienced and projected trends;

4. Concentration of experience within early policy duration;

5. Expected claim fluctuation;

6. Experience refunds, adjustments or dividends;

7. Renewability features;

8. Interest; and

9. Product features such as elimination periods, deductibles and maximum limits.

10. All appropriate expense factors.

11. Experimental nature of the coverage.

12. Policy reserves.

13. Mix of business by risk classification.

(c) An insurer shall submit its calculations of the loss ratio for a long–term care policy at the same time it submits a long–term care policy form and at any time that it makes a filing for rates under a long–term care policy.

(d) The provisions of this subsection apply only to policies issued prior to January 1, 2002.

(6) ANNUAL LOSS RATIO REPORT. An insurer shall annually, not later than April 1, file a report with the office in the form prescribed by the commissioner regarding its loss ratios and loss experience under long–term care policies. The report shall be certified to by a qualified actuary.

(7) LONG–TERM CARE, NURSING HOME AND HOME HEALTH CARE POLICIES, CONTINUATION AND CONVERSION REQUIREMENTS. (a) A group policy, as defined by s. 632.897 (1) (c), Stats., which is a long–term care policy shall provide terminated insureds the right to continue under the group policy as required under s. 632.897, Stats.

(b) An individual long–term care policy that provides coverage for a spouse shall permit the spouse to obtain individual coverage as required under s. 632.897 (9), Stats., upon divorce or annulment.

(c) For the purpose of s. 632.897, Stats., an insurer provides reasonably similar individual coverage to a person converting from a long–term care policy only if the insurer offers an individual policy that is identical to or in excess of the benefits provided under the terminated coverage.

(d) In addition to offering the individual conversion policy as required under par. (c), an insurer may also offer the person the alternative of an individual conversion policy that complies with all of the following:

1. Is not underwritten.

2. Complies with this section and s. Ins 3.46.

3. Provides coverage of care in an institutional setting, if the original policy provided coverage in an institutional setting.

4. Provides coverage of care in a community–based setting, if the original policy provided coverage in a community–based setting.

(e) Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed to the insurer within 30 days after notice of termination of group coverage. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be guaranteed renewable annually.

(f) Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced except when the premium was a composite premium. If the premium for the policy from which conversion is made was a composite premium then at conversion the premium shall be based upon attained age at the time of conversion.

(g) The offer of continuation of coverage or issuance of a converted policy shall comply with s. 632.897, Stats., except when either of the following occurs:

1. Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due.

2. The terminating coverage is replaced not later than 31 days after termination by group coverage effective on the day following the termination of coverage providing benefits identical to or in excess of those provided by the terminating coverage and the premium for which is calculated in a manner consistent with the requirements of par. (f).

(h) Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long–term care insurance policy that provides benefits on the basis of incurred expenses, may contain a provision that results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full

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benefits provided by the converted policy, would result in payment of more than 100% of incurred expenses. The provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund that reflects the reduction in benefits payable.

(i) A converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, may not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

(j) Notwithstanding any other provision of this section, an insured individual whose eligibility for group long−term care coverage is based upon his or her relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

(8) RESERVE STANDARDS FOR LONG−TERM CARE, NURSING HOME AND HOME HEALTH CARE POLICIES AND LIFE INSURANCE−LONG−TERM CARE COVERAGE. (a) 1. Policy reserves for life insurance−long−term care coverage shall be determined in accordance with s. 623.06 (2) (g), Stats. Claim reserves must also be established if a life insurance−long−term care coverage is in claim status.

2. Reserves for coverage subject to this paragraph should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long−term care benefits. However, in no event shall the reserves for the long−term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long−term care benefits.

3. In the development and calculation of reserves for policies and riders subject to this subsection, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

a. Definition of insured events,

b. Covered long−term care facilities,

c. Existence of home convalescence care coverage,

d. Definition of facilities,

e. Existence or absence of barriers to eligibility,

f. Premium waiver provision,

g. Renewability,

h. Ability to raise premiums,

i. Marketing method,

j. Underwriting procedures,

k. Claims adjustment procedures,

L. Waiting period,

m. Maximum benefit,

n. Availability of eligible facilities,

o. Margins in claim costs,

p. Optional nature of benefit,

q. Delay in eligibility for benefit,

r. Inflation protection provisions, and

s. Guaranteed insurability option.

4. Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American academy of actuaries.

(b) Reserves for long−term care policies shall be determined in accordance with s. Ins 3.17 (8) (b) using tables established for reserve purposes by a qualified actuary meeting the requirements of s. Ins 6.12 and acceptable to the commissioner.

(9) LONG−TERM CARE RATE INCREASE STANDARDS. (a) The initial premium rate schedule provided an insured covered by a long−term care policy may not increase during the initial 3 years in which the policy is in force.

(b) Except as provided in par. (d), any increase in the premium rate schedule provided an insured after the initial 3−year period is subject to the following:

1. Any premium rate increase after the initial 3−year period is guaranteed for at least 2 years after its effective date;

2. For those insureds age 75 or above and whose long term care policy(s) has been in force for at least 10 years, no rate increase shall exceed 10%;

3. If an insurer of any long−term care policy increases rates for a policy by more than 50% in any 3−year period, the insurer shall discontinue issuing all long−term care policies in this state for a period of 2 years from the effective date of such rate increase.

a. If an insurer issues both individual and group long−term care policies, the insurer shall discontinue issuing the type of coverage (individual and/or group) for which rates were increased more than 50% in a 3−year period.

b. All rate filings subject to this requirement shall include a past history of all previous rate increases and a certification of the maximum rate increase over the last thirty−five months including the current rate increase as a percent of the premium in the first month of the 35 month period.

c. This provision shall also apply to any replacing insurer which purchases or otherwise assumes a block of long−term care policies from a prior insurer. For purposes of this provision, any rate increases of the prior insurer shall apply to the replacing insurer.

4. The premium charged to an insured may not increase due to either:

a. The increasing age of the insured at ages beyond 65; or

b. The duration the insured has been covered under the policy.

(c) Long−term care policies which provide for inflation protection shall be subject to the restrictions contained in pars. (a) and (b). However, the purchase of additional coverage may not be considered a premium rate increase for purposes of determining compliance with par. (b) at the time additional coverage is purchased. The premium charged for the purchase of additional coverage shall be subject to par. (b) for any subsequent premium rate increases.

(d) The commissioner may institute future rulemaking proceedings to amend the provisions in par. (b) in appropriate circumstances, including the following:

1. Applicable state or federal law is enacted which materially affects the insured risk.

2. Unforeseen changes occur in long−term care delivery, insured morbidity or insured mortality.

3. Judicial interpretations or rulings are rendered regarding policy benefits or benefit triggers resulting in unforeseen claim liabilities.

(e) Except as provided in par. (f) the provisions of this subsection apply only to long−term care insurance policies and certificates issued from August 1, 1996 to December 31, 2001.

(f) The provisions of this subsection do not apply to any group long−term care insurance policy or certificate issued to any labor organization or to any trust or trustee of a fund established by any employer or labor organization for members or former members if the group policy was in force prior to August 1, 1996.

(9m) PREMIUM RATE SCHEDULE INCREASES, REQUESTING AND DETERMINING EXCEPTIONAL RATE INCREASES. (a) An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least 60 days prior to the notice to the policyholders and shall include all of the following:

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1. The required disclosure of rating practices to consumers notice as described under s. Ins 3.46 (9) (b).

2. A certification by a qualified actuary that the premium rate filing is in compliance with the provisions of this subsection and if the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated.

3. An actuarial memorandum justifying the rate schedule change request that includes all of the following:

a. Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale, including all of the following:

i. Annual values for the 5 years preceding and the 3 years following the valuation date shall be provided separately.

ii. Projections including the development of the lifetime loss ratio, unless the rate increase is an exceptional increase.

iii. Projections demonstrating compliance with par. (b).

b. Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse.

c. Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the insurer have been relied on by the actuary.

d. A statement that policy design, underwriting and claims adjudication practice have been taken into consideration.

e. If it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer shall file composite rates reflecting projections of new certificates.

4. A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner.

5. Sufficient information for review of the premium rate schedule increase by the commissioner.

6. For exceptional increases, the projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase. If the commissioner determines that offsets may exist, the insurer shall use appropriate net projected experience.

7. The commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase.

(b) All premium rate schedule increases shall be determined in accordance with all of the following requirements:

1. The commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

2. Exceptional increases shall provide that 70% of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits.

3. Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

a. The accumulated value of the initial earned premium times 58%.

b. Eighty−five percent of the accumulated value of prior premium rate schedule increases on an earned basis.

c. The present value of future projected initial earned premiums times 58%.

d. Eighty−five percent of the present value of future projected premiums not in this subd. 3. c. on an earned basis.

4. If a policy form has both exceptional and other increases, the values in subd. 3. b. and d. shall also include 70% for exceptional rate increase amount.

5. All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in s. Ins 3.17. The actuary shall disclose, as part of the actuarial memorandum, the use of any appropriate averages.

(c) For each rate increase that is implemented, the insurer shall file for review by the commissioner updated projections as defined in par. (a) 3. a. annually for the next 3 years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than 3 years if actual results are not consistent with projected values from prior projections.

(d) If any premium rate in the revised premium rate schedule is greater than 200% of the comparable rate in the initial premium schedule, lifetime projections, as defined in par. (a) 3. a., shall be filed for review by the commissioner every 5 years following the end of the required period in par. (c).

(e) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in par. (b), the commissioner may require the insurer to make premium rate schedule adjustments or take other measures to reduce the difference between the projected and actual experience. In determining whether the actual experience adequately matches the projected experience, consideration should be given to par. (a) 3. e., if applicable.

(f) If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file all of the following:

1. A plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commissioner may impose the condition in par. (g).

2. The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to par. (b) had the greater of the original anticipated lifetime loss ratio or 58% been used in the calculations described in par. (b) 3. a. and c.

(g) 1. For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if significant adverse lapsation has occurred or is anticipated when all of the following conditions occur:

a. The rate increase is not the first rate increase requested for the specific policy form or forms.

b. The rate increase is not an exceptional increase.

c. The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

2. If significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral

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exists, the commissioner may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

3. The offer described in subd. 2. shall be subject to the approval of the commissioner, be based on actuarially sound principles, but not be based on attained age, and shall provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

4. The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. If a rate increase on the policy form, the rate increase shall be limited to the maximum rate increase determined based on the combined experience or the maximum rate increase determined based only on the experience of the insureds originally issued the form plus 10%, whichever is less.

(h) If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long−term care, nursing home, and home health care insurance, the commissioner may, in addition to the provisions of par. (g), either prohibit the insurer from filing and marketing comparable coverage for a period of up to 5 years, or prohibit the insurer from offering all other similar coverages and require the insurer to limit marketing of new applications to the products subject to recent premium rate schedule increases.

(i) Paragraphs (a) through (h) shall not apply to policies for which the benefits provided by the policy are incidental.

(j) Except as provided in pars. (k) and (L) the provisions of this subsection apply to any long−term care, nursing home or home health care policy or certificate issued in this state on or after January 1, 2002.

(k) For group long−term care insurance certificates issued to employer−sponsored groups or labor organizations in this state and in force on or after January 1, 2002 the provisions of this subsection shall apply on the first policy anniversary occurring at least 12 months after January 1, 2002.

(L) In lieu of filing the projections required by pars. (c) and (d) with the commissioner, an insurer may file projections with the employer if that employer has at least 5,000 eligible employees of whom at least 250 are covered under the policy or the employer pays at least 20% of the annual group premium in the year preceding the increase.

(10) INITIAL FILING REQUIREMENTS. (a) This subsection applies to any long−term care, nursing home and home health care policy issued in this state on or after January 1, 2002.

(b) An insurer shall file all of the following with the commissioner at least 30 days before making a long−term care insurance policy available for sale:

1. A copy of the disclosure documents as required by s. Ins 3.46 (9).

2. An actuarial certification consisting of all the following:

a. A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated.

b. A statement that the policy design and coverage provided have been reviewed and taken into consideration.

c. A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration.

d. A complete description of the basis for contract reserves that are anticipated to be held under the form.

e. Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held.

f. A statement that the assumptions used for reserves contain reasonable margins for adverse experience.

g. A statement that the net valuation premium for renewal years does not increase except for attained−age rating where permitted.

h. A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship. If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration under subd. 3. based on a standard age distribution.

i. A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefit or a comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

3. The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.

4. If the commissioner asks for additional information under this provision, the period in par. (b) does not include the period during which the insurer is preparing the requested information.

History: Cr. Register, April, 1991, No. 424, eff. 6−1−91; cr. (9), Register, July, 1996, No. 487, eff. 8−1−96; CR 00−188: cr. (3) (c) to (g), (5) (b) 10. to 13., (d), (9m) and (10), am. (9) (e), r. and recr. (9) (f), Register July 2001, No. 547 eff. 1−1−02; EmR0817: emerg. r. and recr. (3), am. (7) (b) to (d), cr. (7) (e) to (j), eff. 6−3−08; CR 08−032: r. and recr. (3), am. (7) (b) to (d), cr. (7) (e) to (j) Register October 2008 No. 634, eff. 11−1−08; correction in (2) (b) 3. made under s. 13.92 (4) (b) 7., Stats., Register October 2008 No. 634.

Note: CR 08−032 first applies to policies or certificates issued on or after January 1, 2009 or on the first renewal date on or after January 1, 2009, but no later than January 1, 2010 for collectively bargained policies or certificates.

Ins 3.46 Standards for long−term care, nursing home and home health care insurance and life insurance−long−term care coverage. (1) FINDINGS. The findings under s. Ins 3.455 (1) are incorporated by reference. The commissioner finds that the adoption of minimum standards, compensation restrictions and disclosure requirements for long−term care and life insurance−long−term care coverage will reduce marketing abuses and will assist consumers in their attempts to understand the benefits offered and to compare different products. The commissioner finds that failure to comply with this section is misleading and deceptive under s. 628.34 (12), Stats., and constitutes an unfair trade practice.

(2) APPLICABILITY. (b) This section, except for sub. (10) (b) to (e), does not apply to an individual long−term care policy or life insurance−long−term care coverage, to a group long−term care policy or life insurance−long−term care coverage or a certificate under the group policy, or to a renewal policy or coverage or certificate, if:

1. The individual long−term care policy or life insurance−long−term care coverage was issued prior to June 1, 1991; or

2. The group policy is issued prior to June 1, 1991 and all certificates under the policy are issued prior to June 1, 1991.

(c) Section Ins 3.46 in effect prior to June 1, 1991 and sub. (10) (b) to (e) apply to those policies, coverages or certificates which qualify for exemption under par. (b).

(d) This section does not apply to an accelerated benefit coverage of a life insurance policy, rider or endorsement that:

1. Provides payments on the occurrence of a severe illness or injury without regard to the incurral of expenses for services relating to the illness or injury; and

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2. Is not sold primarily for the purpose of providing coverage of nursing home or home health care, or both.

(3) DEFINITIONS. In this section:

(a) "Assisted living facility" or "assisted living care facility" means a living arrangement in which people with special needs reside in a facility that provides supportive services to persons unable to live independently and requires supportive services, including, but not limited to, personal care and assistance taking medications, and that is in compliance with ch. DHS 89.

(b) "Cognitive impairment" means a deficiency in a person's short−term or long−term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

(c) "Compensation" means remuneration of any kind, including, but not limited to, pecuniary or non−pecuniary remuneration, commissions, bonuses, gifts, prizes, awards, finder's fees, and policy fees.

(d) "Department" means the Wisconsin department of health services.

(e) "Group long−term care insurance" means a long−term care insurance policy that is delivered or issued for delivery in this state and issued to one or more employers or labor organizations or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or both, for employees or former employees, or both, or for members or former members, or both, of the labor organizations; or a professional, trade or occupational association for its members or former or retired members, or both, if the association is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation and has been maintained in good faith for purposes other than obtaining insurance or an association or a trust or the trustees of a fund established, created or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering the policy within this state the association or the insurer of the association shall demonstrate that at least 25% of its members are residents of this state.

(f) "Guaranteed renewable for life" means an individual policy renewal provision that continues the insurance in force unless the premium is not paid on time, that prohibits the insurer from changing any provision of the policy, endorsement or rider while the insurance is in force without the express consent of the insured, and that requires the insurer to renew the policy, endorsement or rider for the life of the insured and to maintain the rates in effect for the policy, endorsement or rider at time of issuance, except the provision may permit the insurer to revise rates but on a class basis only.

(g) "Guide to long−term care" means the booklet prescribed by the commissioner which provides information on long−term care, including insurance, and advice to consumers on the purchase of long−term care insurance.

(h) "Home health care services" means medical and non−medical services, provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.

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

(j) "Life insurance−long−term care coverage" means coverage that includes all of the following:

1. Provides coverage for convalescent or custodial care or care for a chronic condition or terminal illness.

2. Is included in a life insurance policy or an endorsement or rider to a life insurance policy.

(k) "Long−term care insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. The term includes group and individual annuities and life insurance policies or riders that provide directly or supplement long−term care insurance. The term also includes a policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term includes qualifying partnership policies. Long−term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization to the extent they are otherwise authorized to issue life or health insurance. Long−term care insurance does not include an insurance policy that is offered primarily to provide basic Medicare supplement coverage. With regard to life insurance, this term does not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump−sum payment for those benefits and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long−term care. Notwithstanding any other provision of this section, any product advertised, marketed or offered as long−term care insurance shall be subject to the provisions of this section.

(L) "Long−term care insurance policy qualifying for the Wisconsin Long−Term Care Insurance Partnership Program" or "qualifying partnership policy" means a long−term care insurance policy that is intended to qualify an insured under the Wisconsin Long−Term Care Insurance Partnership Program, as defined at s. 49.45 (31) (a), Stats.

(m) "Long−term care policy" means a disability insurance policy, or an endorsement or rider to a disability insurance policy, designed or intended primarily to be marketed to provide coverage for care that is convalescent or custodial care or care for a chronic condition or terminal illness. Long−term care policy includes, but is not limited to, a nursing home policy, endorsement or rider and a home health care policy, endorsement or rider. The term does not include any of the following:

1. A Medicare supplement policy, Medicare replacement policy, or an endorsement or rider to such a policy.

2. A continuing care contract, as defined in s. 647.01 (2), Stats.

3. A rider designed specifically to meet the requirements for coverage of skilled nursing care under s. 632.895 (3), Stats.

4. Life insurance−long−term care coverage.

(n) "Medicaid" means the federal and state entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources established by Title XIX, 42 U.S.C. 1396 to 1396r−3. The federal government provides matching funds to the state Medicaid programs.

(o) "Medicare" means the hospital and medical insurance program established by Title XVIII, 42 U.S.C. 1395 to 1395ss, as amended.

(p) "Medicare eligible persons" means persons who qualify for Medicare.

(q) "Mental or nervous disorder" may not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

(r) "Noncancellable" means an individual policy in which the insured has the right to continue the insurance in force by the timely payment of premiums during which period the insurer has

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no right to unilaterally make any change in any provision of the insurance or in the premium rate.

(s) "Outline of coverage" means a document that gives a brief description of benefits in the format prescribed in Appendix 1 to this section and which complies with sub. (8).

(t) "Personal care" means the provision of hands−on services to assist an individual with activities of daily living.

(u) "Qualified long−term care services" means services that meet the requirements of section 7702(c)(1) of the Internal Revenue Code of 1986, as amended, including the following:

1. Necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services.

2. Maintenance or personal care services that are required by a chronically ill individual.

3. Services that are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(v) "Skilled nursing care," "personal care," "home care," "specialized care," "assisted living care," and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care shall be delivered.

(x) "Wisconsin Long−Term Care Insurance Partnership Program" or "state partnership program" means the program developed by the department to meet the requirements of s. 49.45 (31), Stats.

(4) GENERAL FORM REQUIREMENTS FOR LONG−TERM CARE, NURSING HOME AND HOME HEALTH CARE POLICIES AND LIFE INSURANCE−LONG−TERM CARE COVERAGE. Forms for a long−term care policy, life insurance−long−term care coverage and certificates shall:

(a) Provide coverage for each person insured for convalescent and custodial care and care for chronic conditions and terminal illness.

(b) Establish fixed daily benefit limits only if the highest limit is not less than $60 per day. This fixed daily benefit applies to the total long−term care insurance in force for any one insured.

(c) Establish a fixed daily benefit limit based on the level of the covered care only if the lowest limit of daily benefits provided for under the policy or coverage is not less than 50% of the highest limit of daily benefits and the following when applicable:

1. If the policy provides for home health or community care services, it shall provide total home health or community care coverage that is a dollar amount equivalent to at least one−half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement may not apply to policies or certificates issued to residents of continuing care retirement communities.

2. Home health care coverage may be applied to the non−home health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

(d) Provide for an elimination period only if:

1. It is expressed in a number of days per lifetime or per period of confinement;

2. It is clearly disclosed;

3. Days for which Medicare provides coverage are counted for the purpose of determining expiration of the elimination period; and

4. It does not exceed 365 days.

(e) Provide for a lifetime maximum limit only if the limit provides not less than 365 days of coverage. Only days of coverage under the policy, coverage or certificate may be applied against a lifetime maximum limit. Coverage by Medicare may not be applied against a lifetime maximum limit.

(f) Clearly disclose that it does not cover duplicate payments by Medicare for nursing home care or home health care if it has either exclusion.

(g) Provide coverage regardless of whether care is medically necessary. Coverage shall be triggered in conformance with the provisions contained in subs. (17) and (18).

(h) Not limit or condition coverage or benefits by requiring prior hospitalization or prior receipt of care, or benefits for care, in an institutional setting.

(i) Cover irreversible dementia. Coverage may not be excluded or limited on the basis of irreversible dementia.

(j) Define terms used to describe covered services, including, but not limited to, "skilled nursing care," extended care facility," "convalescent nursing home," "personal care," or "home care" services, if those terms are used, in relation to the services and facilities required to be available and the licensure, certification, registration or degree status of those providing or supervising the services. When the definition requires that the provider be appropriately licensed, certified or registered, it shall also state what requirements a provider shall meet in lieu of licensure, certification or registration when the state in which the service is to be furnished does not require a provider of these services to be licensed, certified or registered, or when the state licenses, certifies or registers the providers of services under another name.

(k) All providers of services, including, but not limited to, "skilled nursing facility," "extended care facility," "convalescent nursing home," "personal care facility," "specialized care providers," "assisted living," and "home care agency," shall be defined in relation to the services and facilities required to be available and the licensure, certification, registration or degree status of those providing or supervising the services in the state where the policy was issued. When the definition requires that a provider be appropriately licensed, certified or registered, it shall also state what requirements a provider shall meet in lieu of licensure, certification or registration when the state in which the service is to be furnished does not require a provider of such services to be licensed, certified or registered, or if the state licenses, certifies or registers the provider of services under another name.

(m) Not exclude or limit coverage by type of illness, treatment, medical condition or accident, except it may include exclusions or limits for any of the following:

1. Preexisting conditions or diseases. If a long−term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy and shall be labeled as "Preexisting Condition Limitations."

2. Illness, treatment or medical condition arising out of any one or more of the following:

a. Treatment provided in a government facility, unless otherwise required by law.

b. Services for which benefits are available under Medicare or other governmental programs, except Medicaid, or under a state or federal worker's compensation, employer's liability, occupational disease law, or any motor vehicle no−fault law.

c. Services provided by a member of the insured's immediate family or for which no charge is normally made in the absence of insurance.

d. War or act of war, whether declared or undeclared.

e. Participation in a felony, riot or insurrection.

f. Service in the armed forces or its auxiliary units.

g. Suicide, sane or insane, attempted suicide or intentionally self−inflicted injury.

h. Aviation, however, this exclusion applies only to non−fare−paying passengers.

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3. Mental or nervous disorders; however, this may not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease.

4. Alcoholism or drug addiction.

5. Expenses for services or items available or paid under another long−term care insurance or health insurance policy.

6. This paragraph is not intended to prohibit exclusions or limitation by type of provider. In this subdivision, "state of policy issue" means the state in which the individual policy or certificate was originally issued. However, no long−term care insurer may deny a claim because services are provided in a state other than the state of policy issue when either of the following conditions occurs:

a. When a state other than the state of policy issue does not have the provider licensing, certification, or registration required in the policy, but where the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification or registration.

b. When a state other than the state of policy issue licenses, certifies or registers the provider under another name.

7. This paragraph is not intended to prohibit territorial limitations.

8. If payment of benefits is based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of these terms and include an explanation of the terms in its accompanying outline of coverage and comply with s. Ins 3.60 (5).

9. In the case of a qualified long−term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Medicare or would be so reimbursable but for the application of a deductible or coinsurance amount.

10. Subject to the policy provisions, any plan of care required under the policy shall be provided by a licensed health care practitioner and does not require insurer approval. The insurer may provide a predetermination of benefits payable pursuant to the plan of care. This does not prevent the insurer from having discussions with the licensed health care practitioner to amend the plan of care. The insurer may also retain the right to verify that the plan of care is appropriate and consistent with generally accepted standards.

11. A long−term care policy containing post−confinement, post−acute care, or recuperative benefits shall include in a separate policy provision entitled "Limitation or Conditions on Eligibility for Benefits," the limitations or conditions applicable to these benefits, including any required number of days of confinement.

(n) Not exclude or limit any coverage of care provided in a community−based setting, including, but not limited to, coverage of home health care, by any of the following:

1. Requiring that care be medically necessary.

2. Requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services before community−based care is covered.

3. Limiting eligible services to services provided by registered nurses or licensed practical nurses.

4. Requiring that the insured have an acute condition before community−based care is covered.

5. Limiting benefits to services provided by Medicare certified agencies or providers.

(o) Provide substantial scope of coverage of facilities for any benefits it provides for care in an institutional setting.

(p) Provide substantial scope of coverage of facilities and programs for any benefits it provides for care in a community−based setting.

(q) Contain a description of the benefit appeal procedure and comply with s. 632.84, Stats.

(r) If coverage of care in a community−based setting is included, provide coverage of all types of care provided by state licensed or Medicare certified home health care agencies. A long−term care insurance policy may not, if it provides benefits for home health care or community care services limit or exclude benefits by any of the following acts:

1. Requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided.

2. Requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a home, community or institutional setting before home health care services is covered.

3. Requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide or other licensed or certified home care worker acting within the scope of his or her licensure or certification.

4. Excluding coverage for personal care services provided by a home health aide.

5. Requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service.

6. Requiring that the insured or claimant have an acute condition before home health care services are covered.

7. Limiting benefits to services provided by Medicare−certified agencies or providers.

8. Excluding coverage for adult day care services.

(s) If coverage of care in an institutional setting is provided, not condition eligibility for coverage of custodial or intermediate care on the concurrent or prior receipt of intermediate or skilled care.

(t) Include a provision which allows for reinstatement of coverage, in the event of lapse, if the insurer is provided proof of cognitive impairment or the loss of functional capacity and if the reinstatement of coverage is requested within 5 months after termination and provision is made for the collection of past due premiums, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity to be used in evaluating an application for reinstatement may not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity, if any, contained in the policy and certificate.

(u) Require a signed acceptance by the individual insured for all riders or endorsements added to an individual long−term care insurance policy after the date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy, except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long−term care insurance policy. After the date of issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider, or endorsement.

(5) FORM REQUIREMENTS FOR LONG−TERM CARE, NURSING HOME AND HOME HEALTH CARE POLICIES ONLY. (a) This subsection and ss. Ins 3.13 (2) (j) and 3.39 (9) (a) and ss. 632.76 and 632.897, Stats., do not apply to life insurance−long−term care coverage.

(b) A form for long−term care policy or certificate shall:

1. Comply with the restrictions on preexisting condition provisions under s. 632.76, Stats.

2. Include the unrestricted right to return the policy or certificate within 30 days of the date it is received by the policyholder and comply with s. 632.73 (2m), Stats.

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3. If it is a policy or certificate which covers care in both institutional and community−based settings, contain a caption as follows:

THE WISCONSIN INSURANCE COMMISSIONER HAS ESTABLISHED MINIMUM STANDARDS FOR LONG−TERM CARE INSURANCE.

THIS POLICY MEETS THOSE STANDARDS. THIS POLICY COVERS CERTAIN TYPES OF NURSING HOME AND HOME HEALTH CARE SERVICES. THERE MAY BE LIMITATIONS ON THE SERVICES COVERED. READ YOUR POLICY CAREFULLY.

FOR MORE INFORMATION ON LONG−TERM CARE SEE THE "GUIDE TO LONG−TERM CARE" GIVEN TO YOU WHEN YOU APPLIED FOR THIS POLICY. THIS POLICY'S BENEFITS ARE NOT RELATED TO MEDICARE.

4. If it is a policy or certificate which covers care only in an institutional setting, contain a caption as follows:

THE WISCONSIN INSURANCE COMMISSIONER HAS ESTABLISHED MINIMUM STANDARDS FOR NURSING HOME INSURANCE. THIS POLICY MEETS THOSE STANDARDS.

THIS POLICY COVERS CERTAIN TYPES OF NURSING HOME CARE. THIS POLICY DOES NOT COVER HOME HEALTH CARE. THERE MAY BE LIMITATIONS ON THE SERVICES COVERED. READ YOUR POLICY CAREFULLY.

FOR MORE INFORMATION ON LONG−TERM CARE SEE THE "GUIDE TO LONG−TERM CARE" GIVEN TO YOU WHEN YOU APPLIED FOR THIS POLICY. THIS POLICY'S BENEFITS ARE NOT RELATED TO MEDICARE.

5. If it is a policy or certificate which covers care in a community setting only, contain a caption as follows:

THE WISCONSIN INSURANCE COMMISSIONER HAS ESTABLISHED MINIMUM STANDARDS FOR HOME HEALTH CARE INSURANCE. THIS POLICY MEETS THOSE STANDARDS.

THIS POLICY COVERS CERTAIN TYPES OF HOME HEALTH CARE. THIS POLICY DOES NOT COVER NURSING HOME CARE. THERE MAY BE LIMITATIONS ON THE SERVICES COVERED. READ YOUR POLICY CAREFULLY.

FOR MORE INFORMATION ON LONG−TERM CARE SEE THE "GUIDE TO LONG−TERM CARE" GIVEN TO YOU WHEN YOU APPLIED FOR THIS POLICY. THIS POLICY'S BENEFITS ARE NOT RELATED TO MEDICARE.

6. Contain the caption required under subd. 3., 4. or 5. imprinted on the face of the policy or certificate in type not smaller than 18−point and either in contrasting color from the text or with a distinctly contrasting background which is at least as prominent as contrasting color.

7. Include an extension of benefits provision which provides that if the policy is terminated for any reason, including, but not limited to, failure to pay premium, any benefits provided for care in an institutional setting will continue to be payable for institutionalization if the institutionalization begins when the policy is in force and continues without interruption after termination. This extension of benefits may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy elimination period and all other applicable provisions of the policy.

8. If it is an individual policy, be plainly printed in black or blue ink in a uniform type of a style in general use with not less than 10−point with a lower case unspaced alphabet length not less than 120−point. If it is a group policy, certificates issued under the policy shall be 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.

9. If it is an individual policy, include a provision which provides that the policy is guaranteed renewable for life or noncancellable, then such provision shall be appropriately captioned and shall appear on the first page of the policy and shall include any reservation by the insurer of the right to change premiums and any automatic renewal premium increase based on the policyholder's age.

(6) NURSING HOME AND HOME HEALTH CARE COVERAGE FORMS MAY NOT USE THE TERM "LONG−TERM CARE". Only a form for a long−term care policy, life insurance−long−term care coverage or certificate which provides substantial coverage of care in both an institutional setting and in a community−based setting may use the term "long−term care" or a substantially similar term.

(7) MISREPRESENTATIONS PROHIBITED. (a) No insurer or intermediary may use the term "long−term care" or similar terminology in an advertisement or offer of a policy, coverage or certificate unless the policy, coverage or certificate advertised or offered:

1. Covers care in both institutional and community−based settings;

2. Complies with this section; and

3. Is approved as a long−term care policy or certificate covering care in both institutional and community settings and as appropriately using the term "long−term care" by the office.

(b) No insurer may file a form under s. 631.20, Stats., for a long−term care policy, life insurance−long−term care coverage or certificate, unless the form complies with this section.

(8) OUTLINE OF COVERAGE. (a) An outline of coverage for a long−term care policy, life insurance−long−term care coverage or certificate shall:

1. Have captions printed in 18−point bold letters and conspicuously placed;

2. Be printed in an easy to read type and written in easily understood language; and

3. Comply with s. Ins 3.27 (5) (L) and (9) (zh).

(b) No insurer or intermediary may use an outline of coverage to comply with sub. (9) or advertise, market or offer a long−term care policy, life insurance−long−term care coverage or certificate, unless prior to the use, advertising, marketing or offer the outline of coverage is approved in writing by the office.

(c) Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy all of the following:

1. "Notice to Buyer: This policy may not cover all of the costs associated with long−term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

2. A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation by the insurer of the right to change premium. Continuation or conversion provisions of group coverage shall be specifically described.

(d) This par. does not apply to a group that is offered coverage as a result of collective bargaining and has guaranteed issue.

(9) DISCLOSURE WHEN SOLICITING. (a) An insurer or intermediary at the time the insurer or intermediary contacts a person to solicit the sale of a long−term care policy, life insurance−long−term care coverage or certificate shall deliver to the person:

1. A copy of the current edition of the guide to long−term care; and

2. An outline of coverage.

(b) Other than a policy for which no applicable premium rate or rate schedule increases can be made, an insurer shall provide all of the following information to the applicant at the time of application or enrollment:

1. A statement that the policy may be subject to rate increases in the future.

2. An explanation of potential future premium rate revisions~~,~~ and the policyholder's or certificateholder's option in the event of a premium rate revision.

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3. The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase.

4. A general explanation for applying premium rate or rate schedule adjustments that shall include a description of when premium rate or rate schedule adjustments will be effective, such as next anniversary date~~,~~ or next billing date, and the right to a revised premium rate or rate schedule as provided in subd. 2. if the premium rate or rate schedule is changed.

5. Information regarding each premium rate increase on this policy form or similar policy forms over the past 10 years for this state or any other state that, at a minimum, identifies the policy forms for which premium rates have been increased; the calendar years when the form was available for purchase; and the amount or percentage of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase~~,~~ and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

(c) The insurer may as part of the disclosure under par. (b) in a fair manner, provide additional explanatory information related to the rate increases.

(d) For purposes of the disclosure requirement under par. (b), an insurer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long–term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.

(e) For purposes of the disclosure requirement under par. (b), if an acquiring insurer files for a rate increase on a long–term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of the effective date of this subsection or the end of a 24 month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling insurer shall include the disclosure of that rate increase.

(f) For purposes of the disclosure requirement under par. (b), if the acquiring insurer files for a subsequent rate increase, even within the 24 month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers, the acquiring insurer must make all disclosures required, including disclosure of the earlier rate increase.

(g) An applicant shall sign an acknowledgement at the time of application that the insurer made the disclosure required under par. (b) 1. and 5.

(h) An insurer shall use the forms in Appendices 1, 2 and 5 to comply with the requirements of pars. (b), (g) and (i).

(i) An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least 60 days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by par. (b) when the rate increase is implemented.

(j) This subsection shall apply as follows:

1. Except as provided in subd. 2., this subsection applies to any long–term care, nursing home or home health care policy or certificate issued in this state on or after January 1, 2002.

2. For group long–term care insurance certificates issued to employer–sponsored groups or labor organizations in this state and in force on or after January 1, 2002 the provisions of this subsection shall apply on the first policy anniversary occurring at least 12 months after January 1, 2002.

(k) An insurer shall provide copies of the disclosure forms required in Appendices 2 and 5 to the applicant.

(L) 1. In the case of a group insurance policy defined in s. 600.03 (23), Stats., any requirement that a signature of an insured be obtained by an intermediary or insurer shall be deemed satisfied if all of the following are met:

a. The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. Verification of enrollment and enrollment information shall be provided to the enrollee in writing.

b. The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention and prompt retrieval of records.

c. The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information and personal medical information is maintained.

2. The insurer shall make available, upon request of the commissioner, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

3. This par. does not apply to a group that is offered coverage as a result of collective bargaining and has guaranteed issue.

(m) With regard to life insurance policies that provide an accelerated benefit for long–term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. This paragraph may not apply to qualified long–term care insurance contracts.

(10) UNDERWRITING. (a) No insurer may issue a long–term care policy, life insurance–long–term care coverage or a certificate to an applicant 75 years of age or older, unless prior to issuing coverage the insurer obtains one of the following:

1. A copy of a physical examination.

2. An assessment of functional capacity.

3. An attending physician's statement.

4. Copies of medical records.

(b) An insurer selling or issuing long–term care policies or life insurance–long–term care coverage shall maintain a record of all policies, coverage or certificate rescissions or reformations, including voluntary rescissions or reformations, categorized by policies, coverages and certificates within this state and nationwide.

(c) An insurer subject to par. (b) shall file a report with the office regarding rescissions and reformations not later than March 1 each year on the form prescribed by the commissioner.

(d) An insurer shall maintain a record of its claims administration guidelines for processing claims under long–term care policies and life insurance–long–term care coverage and shall provide the record to the office on request.

(e) Sections Ins 3.28 and 3.31 apply to long–term care policies.

(f) All applications for long–term care insurance policies or certificates, except those that are guaranteed issue, shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant and shall comply with all of the following when applicable:

1. If the application contains a question that asks whether the applicant has had medication prescribed by a physician, it shall also ask the applicant to list the medication that has been prescribed.

2. If the medications listed in the application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the insurer may not rescind the policy or certificate for that condition.

(g) The following language shall be set out in bold font and in a conspicuous location that is in close conjunction with the applicant's signature block on an application for a long–term care insurance policy or certificate:

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"Caution: If your answers on this application are incorrect or untrue, [insurer's name] has the right to deny benefits or rescind your policy."

(h) The following language, or language substantially similar to the following, shall be set out in bold font and in a conspicuous location on the long−term care insurance policy or certificate at the time of delivery:

"Caution: The issuance of this long−term care insurance [policy or certificate] is based upon your responses to the questions on your [application or enrollment form]. A copy of your [application or enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, [the insurer] has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers were incorrect, contact [the insurer] at this address: [insert address].

(i) A copy of the completed application or enrollment form shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

(j) Every insurer or other entity selling or issuing long−term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated and shall annually furnish this information to the commissioner in the format contained in Appendix 8.

(11) SALE OF LONG−TERM CARE AND LIMITED BENEFIT POLICIES; REQUIRED OFFER OF COVERAGE WITH INFLATION PROTECTION. (a) No insurer may advertise, market or offer a long−term care policy or certificate unless the insurer has a form approved under s. 631.20, Stats., for the policy or certificate which adds inflation protection no less favorable than one of the following:

1. Benefit levels and maximum benefit amounts increase annually and are annually compounded at a rate of not less than 5%. The policy or certificate may provide that the individual insured or certificate holder will be permitted to decline a benefit increase and that if any benefit increase is declined future increases will not be available. Declination of a increase must be by express written election at the time the increase is to take effect.

2. Benefit levels and maximum benefit amounts increase annually and are annually compounded at a rate equal to the increase in the consumer price index (urban) for the previous year. The insurer may elect to provide in the form that the individual insured or certificate holder will be permitted to decline a benefit increase and that if the benefit increase is declined future increases will not be available. Such a provision shall provide that declination of an increase shall be by express written election at the time the increase is to take effect.

3. Coverage of a specified percentage, not less than 80%, of actual or reasonable charges for expenses incurred.

4. Activities of daily living and cognitive impairment triggers shall be described in the policy in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits." If an attending physician or other specified person is required to certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified.

(b) No insurer may file a form for a long−term care policy or certificate under s. 631.20, Stats., unless the application form is filed with the policy or certificate form and the application form contains a clear and conspicuous disclosure of the offer required under par. (c).

(c) No insurer or intermediary may contact any person to solicit the sale of a long−term care policy or certificate unless, at the time of contact, the intermediary or insurer makes a clear and conspicuous offer to the person to provide the long−term care policy or certificate with the benefit levels selected by the person and inflation protection as provided under par. (a).

(d) No insurer or intermediary may accept an application for a long−term care policy or certificate unless it is signed by the applicant and the applicant has indicated acceptance or rejection of the inflation protection on the application.

(e) If a long−term care policy is a group policy the applicant for the purpose of par. (d) is the proposed certificate holder.

(f) No insurer or intermediary may advertise or represent that a long−term care policy includes inflation protection unless the policy includes inflation protection at least as favorable as provided under par. (a) 1., 2. or 3.

(g) This subsection does not require an insurer to accept an application for a long−term care policy or certificate with inflation protection as provided by this subsection if the applicant would be rejected under underwriting criteria for the policy or certificate without the inflation protection.

(h) Insurers offering group long−term care policies are exempt from pars. (d) and (e) if they comply with all of the following:

1. The policy is issued to a local, municipal, county, or state public employee group.

2. The group coverage was negotiated as part of a collective bargaining agreement.

3. The group coverage is provided to all eligible employees on a guaranteed issue basis.

4. The policy provides insureds with at least 5% compound annualized inflation protection.

(12) SALE OF LONG−TERM CARE POLICY OR CERTIFICATE OR LIFE INSURANCE−LONG−TERM CARE COVERAGE WITH LENGTHY ELIMINATION PERIOD. (a) No insurer may advertise, market or offer a long−term care policy or certificate, or life insurance−long−term care coverage with an elimination period exceeding 180 days unless the insurer has a form approved under s. 631.20, Stats., providing the identical coverage, but with an elimination period of 180 days or less.

(b) No insurer may file a form for a long−term care policy or certificate or life insurance−long−term care coverage containing an elimination period in excess of 180 days, unless the application form contains a clear and conspicuous disclosure of the offer required under par. (c).

(c) No insurer or intermediary may contact any person to solicit the sale of a long−term care policy or certificate or life insurance−long−term care coverage with an elimination period in excess of 180 days unless, at the time of the contact, the intermediary or insurer makes a clear and conspicuous offer to the person to provide the policy, certificate or coverage with an elimination period of 180 days or less.

(d) No insurer or intermediary may accept an application for a long−term care policy or certificate, or life insurance−long−term care coverage, unless it is signed by the applicant and has indicated acceptance or rejection of the offer required under par. (c) on the application.

(e) If a policy or coverage is a group policy or coverage, the applicant for the purpose of par. (d) is the proposed certificate holder.

(f) This subsection does not require an insurer to accept an applicant for a policy, certificate or coverage with a 180−day or less elimination period if the applicant would be rejected for the same policy, certificate or coverage with the elimination period in excess of 180 days.

(13) COMMISSION LIMITS FOR LONG−TERM CARE, NURSING HOME AND HOME HEALTH CARE POLICIES. (a) An insurer may provide compensation to an intermediary or other representative, and an intermediary or representative may accept compensation for the sale of a long−term care policy or certificate only if:

1. The first year compensation for the sale does not exceed 400% of the compensation paid in the 2nd year or period for the sale or for servicing the policy or certificate; and

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2. The compensation provided in subsequent years is the same as provided in the 2nd year or period and is provided for at least 5 renewal years.

(b) No person may provide compensation to an intermediary, representative or producer, and no intermediary, representative or producer may accept compensation, relating to the replacement of a long−term care policy or certificate which is greater than the renewal compensation provided by the replacing insurer for the replacing policy or certificate. Long−term care policies this paragraph applies to include, but are not limited to, long−term care policies, nursing home policies and home health care policies issued prior to June 1, 1991.

(14) REPLACEMENT; LONG−TERM CARE, NURSING HOME AND HOME HEALTH CARE POLICIES. (a) If a long−term care policy or certificate replaces another long−term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new long−term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

(b) If a group long−term care policy is replaced by another group long−term care policy purchased by the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy may not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(c) 1. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long−term care insurance policy or certificate in force or whether a long−term care policy or certificate is intended to replace any other accident and sickness or long−term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing the following questions may be used:

a. Do you have another long−term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)?

b. Did you have another long−term care insurance policy or certificate in force during the last 12 months?

c. If so, with which [company or insurer]?

d. If that policy lapsed, when did it lapse?

e. Are you covered by Medicaid?

f. Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

2. Agents shall list any other health insurance policies they have sold to the applicant, including all of the following:

a. List policies sold that are still in force.

b. List policies sold in the past 5 years that are no longer in force.

3. Upon determining that a sale will involve replacement, an insurer; other than an insurer using direct response solicitation methods, or its intermediaries; shall furnish the applicant, prior to issuance or delivery of the individual long−term care insurance policy, a notice regarding replacement of accident and sickness or long−term care coverage. One copy of the notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in compliance with Appendix 6.

4. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long−term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in compliance with Appendix 7.

5. Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Notice shall be made within 5 working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

6. Life insurance policies that accelerate benefits for long−term care shall comply with this section if the policy being replaced is a long−term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of s. Ins 2.07. If a life insurance policy that accelerates benefits for long−term care is replaced by another such policy, the replacing insurer shall comply with both the long−term care and the life insurance replacement requirements.

(d) An intermediary taking an application for a long−term care policy or certificate shall do all of the following:

1. List any other health insurance policies or certificates the intermediary has sold to the applicant.

2. List separately the policies or certificates that are still in force.

3. List policies or certificates sold in the past which are no longer in force.

4. Submit the lists to the insurer with the application.

(e) Every insurer and person marketing long−term care insurance coverage in this state, directly or through its intermediaries, shall do all of the following:

1. Establish marketing procedures to assure that any comparison of policies by its intermediaries or other producers will be fair and accurate.

2. Establish marketing procedures to assure excessive insurance is not sold or issued.

3. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for a long−term care policy or certificate already has an accident and sickness or a long−term care policy or certificate and the types and amounts of any such insurance, except that in the case of qualified long−term care insurance contract, an inquiry into whether a prospective applicant or enrollee for long−term care insurance has accident and sickness insurance is not required.

4. Establish auditable procedures for verifying compliance with this paragraph.

(f) In recommending the purchase or replacement of any long−term care policy or certificate an intermediary shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(g) Replacement of long−term care, nursing home and home health care policies and certificates issued prior to June 1, 1991 is also subject to this subsection.

(15) UNINTENTIONAL LAPSE; LONG−TERM CARE, NURSING HOME AND HOME HEALTH CARE POLICIES. (a) As part of the application process, an insurer shall obtain from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive a notice of lapse or termination of the policy or certificate for nonpayment of premium or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. Designation may not constitute acceptance of any liability by the third party for services provided to the insured. The written designation shall include the following:

1. Space for clearly listing at least one person.

2. The person's name and address.

3. In the case of an applicant who elects not to designate an additional person, the waiver shall state, "Protection against unintentional lapse. I understand that I have a right to designate at least one person, other than myself, to receive notice of lapse

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or termination of this policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect **NOT** to designate any person to receive such notice."

(b) For those insureds who designate another person as provided in par. (a), the insurer, after the policy or certificate is issued shall send a letter to the designated person indicating that the insured has designated the person to receive notice of lapse or termination of the insured's long−term care, nursing home or home health care policy or certificate. The letter shall ask the person to correct any information concerning the name or address of the person. It shall also explain the rights and duties of the designated person.

(c) Not less than once every 2 years an insurer shall notify its policyholders of their right to designate a person to receive the notices contained in par. (a). The notification shall allow policyholders to change, add to or, in the case of those policyholders who elected not to designate a person, designate a person to receive the notices provided in par. (a).

(d) When an insured pays premium through a payroll deduction plan, the requirements contained in par. (a) need not be met until 60 days after the insured is no longer on a payroll deduction plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

(e) No long−term care, nursing home, or home health care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days before the effective date of the lapse or termination, has given notice to the insured and to those designated by the insured pursuant to par. (a) at the address provided by the insured for purposes of receiving notices of lapse or termination. Notice may not be given until 30 days after a premium is due and unpaid.

(16) SUITABILITY; LONG−TERM CARE, NURSING HOME AND HOME HEALTH CARE POLICIES. (a) This subsection may not apply to life insurance policies that accelerate benefits for long−term care.

(b) Every insurer marketing long−term care insurance policies shall do all of the following:

1. Develop and use suitability standards to determine whether the purchase or replacement of long−term care insurance is appropriate for the needs of the applicant.

2. Train its agents in the use of its suitability standards.

3. Maintain a copy of its suitability standards.

4. Report annually to the commissioner all of the following:

a. The total number of applications received from residents of this state.

b. The number of those who declined to provide information on the personal worksheet.

c. The number of applicants who did not meet the suitability standards.

d. The number of applicants who chose to confirm after receiving a suitability letter.

(c) 1. To determine whether the applicant meets the standards developed by the insurer, the agent and insurer shall develop procedures that take the following into consideration:

a. The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage.

b. The applicant's goals or needs with respect to long−term care and the advantages and disadvantages of insurance to meet these goals or needs.

c. The values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

2. The insurer, and where an agent is involved, the agent shall make reasonable efforts to obtain the information set out in subd. 1. The efforts shall include presentation to the applicant, at or prior to application, the "Long−Term Care Insurance Personal Worksheet." The personal worksheet used by the insurer shall contain, at a minimum, the information in the format contained in Appendix 2, in not less than 12 point type. The insurer may request the applicant to provide additional information to comply with its suitability standards. A copy of the insurer's personal worksheet shall be filed with the commissioner.

3. A completed personal worksheet shall be returned to the insurer prior to the insurer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long−term care insurance to employees and their spouses.

4. The sale or dissemination outside the company or agency by the insurer or agent of information obtained through the personal worksheet in Appendix 2 is prohibited.

(d) The insurer shall use the suitability standards it has developed pursuant to this section in determining whether issuing long−term care insurance coverage to an applicant is appropriate.

(e) Agents shall use the suitability standards developed by the insurer in marketing long−term care insurance.

(f) At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long−Term Care Insurance" shall be provided. The form shall be in the format contained in Appendix 3, in not less than 12 point type.

(g) If the insurer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the insurer may reject the application. In the alternative, the insurer shall send the applicant a letter similar to the sample letter in Appendix 4. However, if the applicant has declined to provide financial information, the insurer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

(h) The insurer shall maintain and have available for review by the commissioner the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who, after receiving a suitability letter, indicated that the insurer should resume processing the application.

(17) STANDARDS FOR BENEFIT TRIGGERS; LONG−TERM CARE, NURSING HOME AND HOME HEALTH CARE POLICIES. (a) The following definitions apply to this subsection:

1. "Activities of daily living" includes at least bathing, continence, dressing, eating, toileting, and transferring.

2. "Bathing" means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

3. "Cognitive impairment" means a deficiency in a person's short− or long−term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

4. "Continence" means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for catheter or colostomy bag.

5. "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

6. "Eating" means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

7. "Hands−on assistance" means physical assistance, either minimal, moderate or maximal, without which the individual would not be able to perform the activity of daily living.

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8. "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

9. "Transferring" means moving into or out of a bed, chair or wheelchair.

(b) A long−term care, nursing home only and home health care only policy or certificate shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits may not be more restrictive than requiring either a deficiency in the ability to perform not more than 3 of the activities of daily living or the presence of cognitive impairment.

(c) 1. Activities of daily living shall include at least those contained in the definition in par. (a).

2. Insurers may use deficiencies to perform activities of daily living to determine when covered benefits are payable in addition to those contained in par. (a) as long as they are defined in the policy.

(d) An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however, the provisions may not restrict, and are not in lieu of, the requirements contained in pars. (b) and (c).

(e) For purposes of this section, the determination of a deficiency may not be more restrictive than any of the following:

1. Requiring hands−on assistance of another person to perform the prescribed activities of daily living.

2. If the deficiency is due to the presence of cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured and others.

(f) Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers.

(g) Long−term care, nursing home only and home health care only policies shall include a clear description of the process for appealing and resolving benefit determinations.

Note: The rule revision effective August 1, 1996 applies to any policy solicited, delivered or issued after September 1, 1996. After August 1, 1996 but before September 1, 1996, the insurer may market policies under either the current rule or the revised rule, if a policy form conforming to this section has been approved.

(18) TAX QUALIFIED LONG TERM CARE, NURSING HOME AND HOME HEALTH CARE POLICIES. This subsection applies to long term care, nursing home or home health care policies which are intended to be tax qualified under and comply with the requirements of section 7702B of the Internal Revenue Code of 1986, as amended, and any regulations and administrative pronouncements issued under the Code.

(a) In order to qualify for certain tax treatment, long term care, nursing home only and home health care only policy provisions may contain the following conditions as defined in section 7702B of the Internal Revenue Code of 1986 as amended and any regulations and administrative pronouncements issued thereunder notwithstanding sub. (17):

1. The terms "severe cognitive impairment " and "substantial supervision" may be used in lieu of the term "cognitive impairment" and its accompanying supervision requirement may be used as a benefit trigger in sub. (17) (a) 3. and (e) 2.

2. The term "substantial assistance" may be used in lieu of the term "hands−on−assistance" in sub. (17) (c) 1.

3. The requirement that the claimant obtain a certification from a licensed health care practitioner, as defined in section 7702B of the Internal Revenue Code of 1986, as amended, and any regulations and administrative pronouncements issued under the Code, as a condition for claim payment that the functional incapacity or inability to perform at least 2 activities of daily living triggering benefits under the policy is expected to last at least 90 days, may be imposed by the insurer.

4. Except as noted in subds. 1., 2. and 3., the definitions and provisions in sub. (17) apply to this subsection.

(b) The policy shall contain a clear disclosure that the policy is intended to be a tax qualified long term care policy.

(c) The outline of coverage shall prominently disclose that, in order to meet the requirements of a tax qualified policy, the functional incapacity or inability to perform activities of daily living triggering benefits under the policy must be expected to last for at least 90 days.

(d) All other applicable provisions in this section or s. Ins 3.455 shall continue to apply to tax qualified long term care, nursing home and home health care policies.

(19) NONFORFEITURE BENEFIT REQUIREMENTS FOR LONG–TERM CARE. (a) No insurer may advertise, market or offer a long–term care, nursing home only or home health care only policy or certificate unless the insurer offers, at the time of sale, a shortened benefit period nonforfeiture benefit.

(b) If the offer required to be made under par. (a) is rejected, the insurer shall provide the contingent benefit upon lapse described in this section.

(c) 1. After rejection of the offer required under par. (a) for individual and group policies without nonforfeiture benefits issued after the effective date of this subsection, the insurer shall provide a contingent benefit upon lapse.

2. If a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

3. The contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in the table in the subdivision based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least 60 days prior to the due date of the premium reflecting the rate increase.

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Triggers for a Substantial Premium Increase	
Issue Age	% Increase Over Initial Premium
29 and under	200%
30−34	190%
35−39	170%
40−44	150%
45−49	130%
50−54	110%
55−59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

4. On or before the effective date of a substantial premium increase as described in subd. 3. the insurer shall do all of the following:

a. Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased.

b. Offer to convert the coverage to a paid−up status where the amount payable for each benefit is 90% of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the 120−day period referenced in subd. 3.

c. Notify the policyholder or certificateholder that a default or lapse at any time during the 120−day period referenced in subd. 3. shall be deemed to be the election of the offer to convert in subd. 4. b., if the ratio is 40% or more.

(d) The required benefits continued as nonforfeiture benefits under par. (a), including contingent benefits upon lapse under par. (b), are computed as follows:

1. "Attained age rating" as applied in this paragraph is defined as a schedule of premiums starting from the issue date which increases with age at least 1% per year prior to age 50, and at least 3% per year for age 50 and beyond.

2. The nonforfeiture benefit shall provide paid−up long−term care, nursing home only or home care only insurance coverage after lapse. The amounts and frequency of benefits in effect at the time of lapse, but not increased thereafter, shall be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in subd. 3.

3. The standard nonforfeiture credit shall be at least 100% of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit may not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of par. (e).

4. The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first 3 years and subsequent years. For a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of end of the tenth year following the policy or certificate issue date or of the end of the second year following the date the policy or certificate is no longer subject to attained age rating.

5. Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

(e) All benefits paid by the insurer while the policy or certificate is in premium–paying status and in the paid−up status may not exceed the maximum benefits which would have been payable if the policy or certificate had remained in premium−paying status.

(f) There shall be no difference in the minimum nonforfeiture benefits as required under this subsection for group and individual policies.

(g) Premiums charged for a policy or certificate containing nonforfeiture benefits shall be subject to the loss ratio requirements contained in s. Ins 3.455 (5) treating the policy as a whole.

(h) This subsection shall apply as follows:

1. Except as provided in subd. 2., the provisions of this subsection apply to any long−term care, nursing home, and home health care policy issued in this state on or after January 1, 2002.

2. For group long−term care, nursing home, and home health care insurance certificates issued to employer−sponsored groups or labor organizations in this state and in force on or after January 1, 2002, which policy was in force on January 1, 2001, the provisions of this subsection shall not apply.

(i) To determine whether contingent nonforfeiture upon lapse provisions are triggered under par. (c) 3. a replacing insurer that purchased or otherwise assumed a block or blocks of long−term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

(j) A contingent benefit on lapse shall also be triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in

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par. (c) 3. based on the insured's issue age, the policy or certificate lapses within 120 days of the due date of the premium so increased, and the ratio is 40% or more. Unless otherwise required, policyholders shall be notified at least 30 days prior to the due date of the premium reflecting the rate increase.

(20) INCONTESTABILITY PERIOD. An insurer may rescind a long−term care insurance policy or certificate or deny an otherwise valid long−term care insurance claim only as permitted under ss. 631.11 (1) (b) and 632.76, Stats., and only if in addition to complying with ss. 631.11 (1) (b) and 632.76, Stats., any of the following apply:

(a) For a policy or certificate that has been in force for less than 6 months, the insurer shows the misrepresentation is material to the acceptance for coverage.

(b) For a policy or certificate that has been in force for at least 6 months but less than 2 years, the insurer shows the misrepresentation is both material to the acceptance for coverage and pertains to the condition for which benefits are sought.

(c) For a policy or certificate that has been in force 2 years or more, the insurer shows that the insured knowingly, intentionally and fraudulently misrepresented relevant facts relating to the insured's health.

(d) 1. No long−term care insurance policy or certificate may be field issued based on medical or health status unless the compensation to the field issuer is not based on the number of policies or certificates issued.

2. For purposes of this paragraph, a policy or certificate that is "field issued" means the producer or third−party administrator using the insurer's underwriting guidelines underwrites the policy not the insurer, pursuant to the authority granted to the producer or third−party administrator by an insurer.

(e) If an insurer has paid benefits under the long−term care insurance policy or certificate, the benefit payments may not be recovered by the insurer in the event that the policy or certificate is rescinded.

(f) In the event of the death of the insured, this subdivision may not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long−term care. In this situation, the remaining death benefits under these policies shall be governed by s. 632.46, Stats. In all other situations, this subdivision shall apply to life insurance policies that accelerate benefits for long−term care.

(21) REPORTING REQUIREMENTS. (a) Every insurer shall maintain records for each intermediary of that intermediary's amount of replacement sales as a percent of the intermediary's total annual sales and the amount of lapses of long−term care insurance policies sold by the intermediary as a percent of the intermediary's total annual sales.

(b) Every insurer shall report annually by June 30 the 10% of its intermediaries with the greatest percentages of lapses and replacements as measured by par. (a) using Appendix 10.

(c) Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely intermediary activities regarding the sale of long−term care insurance.

(d) Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year using Appendix 10.

(e) Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year using Appendix 10.

(f) Every insurer shall report annually by June 30, for qualified long−term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied using Appendix 9.

(22) FILING REQUIREMENTS FOR ADVERTISING. Every insurer, health care service plan or other entity providing long−term care insurance or benefits in this state shall provide a copy of any long−term care insurance advertisement whether through written, radio or television medium to the commissioner as required by s. Ins 3.27. In addition, all advertisements shall be retained by the insurer, health care service plan or other entity for at least 3 years from the date the advertisement was first used.

(23) STANDARDS FOR MARKETING. (a) Every insurer or other entity marketing long−term care insurance coverage in this state, directly or through its intermediaries, shall do all of the following:

1. Establish marketing procedures and intermediary training requirements to assure that both of the following are met:

a. Any marketing activities, including any comparison of policies, by its intermediaries or other producers will be fair and accurate.

b. Excessive insurance is not sold or issued.

2. Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following notice:

"Notice to buyer: This policy may not cover all of the costs associated with long−term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

3. Provide copies of the disclosure forms required in Appendices 2 and 3 to the applicant.

4. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long−term care insurance already has accident and sickness or long−term care insurance and the types and amounts of any such insurance, except that in the case of qualified long−term care insurance contracts as defined in s. Ins 3.465 (2) (d), an inquiry into whether a prospective applicant or enrollee for long−term care insurance has accident and sickness insurance is not required.

5. Every insurer or entity marketing long−term care insurance shall establish auditable procedures for verifying compliance with this paragraph.

6. If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program, the insurer shall, at solicitation, provide written notice to the prospective policyholder and certificateholder that the program is available and the name, address and telephone number of the program.

7. For long−term care insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms with sub. (3) (f).

8. Provide an explanation of contingent benefit upon lapse provided for in sub. (19) (c), and, if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying periods in sub. (15) (e).

(b) In addition to the practices prohibited in s. 628.34 (12), Stats., the following acts and practices are prohibited by insurers or other entities marketing long−term care insurance coverage in this state, directly or through its intermediaries:

1. "Twisting." Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy or to take out a policy of insurance with another insurer.

2. "High pressure tactics." Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

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3. "Cold lead advertising." Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

4. "Misrepresentation." Misrepresenting a material fact in selling or offering to sell a long−term care insurance policy.

(c) In regards to any transaction involving a long−term care insurance product, no person subject to regulation under chs. 600 to 655, Stats., may knowingly prevent or dissuade or attempt to prevent or dissuade, any person from any of the following:

1. Filing a complaint with the office of the commissioner of insurance.

2. Cooperating with the office of the commissioner of insurance in any investigation.

3. Attending or giving testimony at any proceeding authorized by law.

(d) If an insured exercises the right to return a policy during the free−look period, the issuer shall mail the entire premium refund directly to the person who paid the premium.

(e) 1. With respect to the obligations set forth in this subsection, the primary responsibility of an association, as described in s. 600.01 (1) (b) 3., Stats., when endorsing or selling long−term care insurance shall be to educate its members concerning long−term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

2. The insurer shall file with the office of the commissioner of insurance all of the following material:

a. The policy and certificate.

b. A corresponding outline of coverage.

c. All advertisements requested by the insurance department.

3. The association shall disclose in any long−term care insurance solicitation the following:

a. The specific nature and amount of the compensation arrangements, including all fees, commissions, administrative fees and other forms of financial support, that the association receives from endorsement or sale of the policy or certificate to its members.

b. A brief description of the process under which the policies and the insurer issuing the policies were selected.

4. If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.

5. The board of directors of associations selling or endorsing long−term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer.

6. The association shall also do all of the following:

a. Conduct an examination of its policies, including benefits, features, and rates and subsequently update the examination in the event of material change at the time of the association's decision to endorse or engage the services of a person with expertise in long−term care insurance not affiliated with the insurer.

b. Actively monitor the marketing efforts of the insurer and its intermediaries.

c. Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.

d. Subd. 6. a. to c. may not apply to qualified long−term care insurance contracts.

7. No group long−term care insurance policy may be issued to an association unless the insurer files with the office of the commissioner of insurance the information required in this subsection.

8. An insurer may not issue a long−term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in this subsection.

9. Failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice in violation of s. 628.34 (11), Stats.

(24) AVAILABILITY OF NEW SERVICES OR PROVIDERS. (a) An insurer shall notify policyholders of the availability of a new long−term care policy series that provides coverage for new long−term care services or providers material in nature and not previously available through the insurer to the general public. The notice shall be provided within 12 months of the date the new policy series is made available for sale in this state.

(b) Notwithstanding par. (a), notification is not required for any policy issued prior to the effective date of this section or to any policyholder or certificateholder who is eligible for benefits, is within an elimination period or is receiving benefits, or who previously received benefits under the terms of the policy, or who would not be eligible to apply for coverage due to issue age limitations under the new policy. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

(c) The insurer shall make the new coverage available in one of the following ways:

1. By adding a rider to the existing policy and charging a separate premium for the new rider based on the insured's attained age.

2. By exchanging the existing policy or certificate for one with an issue age based on the present age of the insured and recognizing past insured status by granting premium credits toward the premiums for the new policy or certificate. The premium credits shall be based on premiums paid or reserves held for the prior policy or certificate.

3. By exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status shall be recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged. The cost for the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate.

(d) An insurer is not required to notify policyholders of a new proprietary policy series created and filed for use in a limited distribution channel. For purposes of this paragraph, "limited distribution channel" means through a discrete entity, such as a financial institution or brokerage, for which specialized products are available that are not available for sale to the general public. Policyholders that purchased such a proprietary policy shall be notified when a new long−term care policy series that provides coverage for new long−term care services or providers material in nature is made available to that limited distribution channel.

(e) Policies issued pursuant to this subsection may not be considered replacements.

(f) Where the policy is offered through an employer, labor organization, or professional, trade or occupational association, the required notification in par. (a) shall be made to the offering entity.

(g) Nothing in this subsection shall prohibit an insurer from offering any policy, rider, certificate or coverage change to any policyholder or certificateholder. However, upon request any policyholder may apply for available coverage that includes the new services or providers. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

(h) This subsection does not apply to life insurance policies or riders containing accelerated long−term care benefits.

(25) RIGHT TO REDUCE COVERAGE AND LOWER PREMIUMS. (a) 1. Every long−term care insurance policy and certificate shall

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include a provision that allows the policyholder or certificateholder to reduce coverage and lower the policy or certificate premium in at least one of the following ways:

a. Reducing the maximum benefit.

b. Reducing the daily, weekly or monthly benefit amount.

2. The insurer may also offer other reduction options that are consistent with the policy or certificate design or the insurer's administrative processes.

(b) The provision shall include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.

(c) The age to determine the premium for the reduced coverage shall be based on the age used to determine the premiums for the existing coverage.

(d) The insurer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable.

(e) If a policy or certificate is due to lapse, the insurer shall provide a written reminder to the policyholder or certificateholder of his or her right to reduce coverage and premiums in the notice required by sub. (15) (e).

(f) This subsection does not apply to life insurance policies or riders containing accelerated long−term care benefits.

(26) INSURANCE INTERMEDIARY TRAINING REQUIREMENTS. This section applies to all insurance intermediaries that sell, solicit or negotiate long−term care insurance products in this state. For purposes of this paragraph, an hour of training means a period of study consisting of no less than 50 minutes. The requirements of this paragraph do not supersede any other intermediary education requirements contained in chs. Ins 26 and 28.

(a) No insurance intermediary may sell, solicit or negotiate long−term care insurance in this state unless the intermediary is duly licensed and appointed by an insurer and has completed the initial training and ongoing training every 24 months as specified in s. 628.348 (1), Stats. The insurer shall be able to verify compliance with the training requirements as specified in this paragraph and s. 628.348 (2), Stats. The training shall meet the requirements set forth in this paragraph to par. (d).

1. a. Initial training. The initial training required shall be no less than 8 hours, of which 2 hours shall contain Wisconsin specific Medicaid and long−term care information. Training shall be completed in one six−hour course for non−Wisconsin specific Medicaid and long−term care information training and one two−hour course for Wisconsin specific Medicaid and long−term care information or one eight−hour course that includes the two−hours of training containing specific Medicaid and long−term care information.

b. Ongoing training. After completion of the initial 8 hours of training, all insurance intermediaries shall complete one 4−hour of training course specific to long−term care insurance and shall incorporate updates to the state partnership program as is available from the department's website. Training shall be completed as specified in par. (b) 2.

2. The training specified in this subsection may not include training that is insurer or company product specific or that includes any sales or marketing information, materials, or training, other than those required by state or federal law.

3. The training required by this subsection shall be submitted and approved and may be approved as continuing education courses under ch. Ins 28.

4. The training required by this subsection shall consist of topics related to long−term care insurance, long−term care services and the state partnership program. The training shall include, but not be limited to, all of the following:

a. State and federal regulations and requirements and the relationship between qualified state long−term care partnership plan policies and other public and private coverage of long−term care services, including Medicaid programs in this state.

b. Available long−term care services and providers.

c. Changes or innovations in long−term care services or providers.

d. Alternatives to the purchase of private long−term care insurance.

e. The effect of inflation on benefits and the importance of inflation protection.

f. Insurance suitability standards and guidelines.

6. Wisconsin specific Medicaid and long−term care training shall consist of the training developed and made available by the department.

7. Satisfaction of the training requirements in any state shall be deemed to satisfy the training requirements in this state subject to verification and compliance with the training requirements in subd. 1. except for the initial 2 hours of Wisconsin specific Medicaid and long−term care information training.

(b) 1. Insurance intermediaries licensed prior to January 1, 2009, shall complete the initial training prior to selling long−term care products on or after January 1, 2009. Completion of initial training courses on or after October 27, 2007, that meet the requirements of par. (a) 4., may be counted towards completion of the initial 8 hour training requirement.

2. For purposes of complying with s. 628.348 (1), Stats., compliance with this subsection will comply with s. 628.348 (1), Stats. Insurance intermediaries who complete initial training by January 1, 2009, are required to complete the required 4 hours of ongoing training by the first complete license renewal cycle as specified in s. Ins 6.63. Insurance intermediaries completing initial training after January 1, 2009 shall complete the required 4 hours of ongoing training by the date of their next complete license renewal cycle as specified in s. Ins 6.63.

(c) Insurers subject to this section shall obtain and maintain verification that the intermediaries appointed with the insurer received the training required by sub. (1) and shall make such information available to the commissioner upon request.

(d) Insurers offering long−term care insurance intended as a qualifying partnership policy shall maintain records that its authorized insurance intermediaries have demonstrated an understanding of the state partnership program and the relationship of the state partnership program to public and private coverage of long−term care including Wisconsin Medicaid long−term care programs. Information maintained shall be in a form that allows the commissioner to provide assurance to the department that the insurer's intermediaries have received the long−term care insurance training.

Note: The amendment to sub. (4) (g) and creation of sub. (18) first applies to any tax qualified long term policy solicited in Wisconsin after December 31, 1996.

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; r. and recr., Register, April, 1991, No. 424, eff. 6−1−91; cr. (3) (cm), (4) (t), (9) (b), (11m), (15), (16), (17), am. (4) (b), (g), renum. (9) (intro.), (a) and (b) to be (9) (a) (intro.), (a) 1. and 2., Register, July, 1996, No. 487, eff. 8−1−96; am. (4) (g) and cr. (18), Register, August, 1997, No. 500, eff. 9−1−97; r. (9) (b), Register, January, 1999, No. 517, eff. 2−1−99; CR 00−188: cr. (3) (j), (4) (u), (9) (b) to (j) and (19), am. (5) (b) 5. and 9., r. (11m), Register July 2001, No. 547 eff. 1−1−02; EmR0817: emerg. r. (2) (a), am. (2) (d) (intro.), (4) (c), (j) to (n), (r), (5) (a), (b) 9., (16) (b), r. and recr. (3), (14), (19) (c) 4. and (d), cr. (8) (c), (d), (9) (k) to (m), (10) (f) to (j), (11) (a) 4., (19) (j) and (20) to (26), eff. 6−3−08; CR 08−032: r. (2) (a), am. (2) (d) (intro.), (4) (c), (j) to (n), (r), (5) (a), (b) 9., (16) (b), r. and recr. (3), (14), (19) (c) 4. and (d), cr. (8) (c), (d), (9) (k) to (m), (10) (f) to (j), (11) (a) 4., (h), (19) (j) and (20) to (26) Register October 2008 No. 634, eff. 11−1−08; corrections in (3) (a), (11) (h) and (20) made under s. 13.92 (4) (b) 1. and 7., Stats., Register October 2008 No. 634.

Note: CR 08−032 first applies to policies or certificates issued on or after January 1, 2009 or on the first renewal date on or after January 1, 2009, but no later than January 1, 2010 for collectively bargained policies or certificates.

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Ins 3.46 APPENDIX 1
(COMPANY NAME)

OUTLINE OF COVERAGE

(Insert the appropriate caption stated below.)

1. This policy is [an individual policy of insurance]([a group policy] that was issued in the [indicate jurisdiction in which group policy was issued]).

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

3. FEDERAL TAX CONSEQUENCES.

   This [POLICY] [CERTIFICATE] is intended to be a federally tax−qualified long−term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

   OR

   Federal Tax Implications of this [POLICY] [CERTIFICATE]. This [POLICY] [CERTIFICATE] is not intended to be a federally tax−qualified long−term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986 as amended. Benefits received under the [POLICY] [CERTIFICATE] may be taxable as income.

4. Terms Under Which the Policy OR Certificate May Be Continued in Force or Discontinued.

   (a) [For long−term care insurance policies or certificates describe one of the following permissible policy renewability provisions:

      (1) Policies and certificates that are guaranteed renewable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy, [certificate] to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

      (2) [Policies and certificates that are noncancellable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELLABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

   (b) [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;]

   (c) [Describe waiver of premium provisions or state that there are not such provisions.]

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.

   [In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium, and if a right exists, describe clearly and concisely each circumstance under which the premium may change.]

6. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

   (a) [Provide a brief description of the right to return–"free look" provision of the policy.]

   (b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

   (a) [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government or any state government.

   (b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.

8. LONG−TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

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This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long−term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

9. BENEFITS PROVIDED BY THIS POLICY.

(a) [Covered services, related deductibles, waiting periods, elimination periods and benefit maximums.]

(b) [Institutional benefits, by skill level.]

(c) [Non−institutional benefits, by skill level.]

(d) Eligibility for Payment of Benefits

[Activities of daily living and cognitive impairment shall be used to measure an insured's need for long−term care and shall be defined and described as part of the outline of coverage.]

[Any additional benefit triggers shall also be explained. If these triggers differ for different benefits, explanation of the triggers shall accompany each benefit description. If an attending physician or other specified person shall certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified.]

10. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Non−eligible facilities and providers;

(c) Non−eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(d) Exclusions and exceptions;

(e) Limitations.]

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in Number 9 above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG−TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long−term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

(a) That the benefit level will not increase over time;

(b) Any automatic benefit adjustment provisions;

(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;

(e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision that provides preconditions to the availability of policy benefits for such an insured.]

13. PREMIUM.

[(a) State the total annual premium for the policy;

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium that corresponds to each benefit option.]

14. ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used;

(b) Describe other important features.]

15. CONTACT THE WISCONSIN SENIOR HEALTH INSURANCE INFORMATION PROGRAM OR YOUR COUNTY BENEFIT SPECIALIST IF YOU HAVE GENERAL QUESTIONS REGARDING LONG−TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG−TERM CARE INSURANCE POLICY OR CERTIFICATE.

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Ins 3.46 APPENDIX 2
LONG−TERM CARE INSURANCE
Personal Worksheet

People buy long−term care insurance for a variety of reasons. These reasons include avoiding spending assets for long−term care, to make sure there are choices regarding the type of care received, to protect family members from having to pay for care, or to decrease the chances of going on Medicaid. However, long−term care insurance can be expensive and is not appropriate for everyone. State law requires the insurance company to ask you to complete this worksheet to help you and the insurance company determine whether you should buy this policy.

PREMIUM

Policy Form Number(s) _____

The premium for the coverage you are considering will be [$_____ per month, or $_____ per year,] [a one−time single premium of $_____.]

Type of Policy (noncancellable/guaranteed renewable): _____

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] [Insurers shall use appropriate bracketed statement. Rate guarantees may not be shown on this form.]

Note: The insurer shall use the bracketed sentence or sentence applicable to the product offered. If a company includes a statement regarding not having raised rates, it shall disclose the company's rate increases under prior policies providing essentially similar coverage.

RATE INCREASE HISTORY

The company has sold long−term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long−term care policy it has sold in this state or any other state.] [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years.] [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increase(s).]

QUESTIONS RELATED TO YOUR INCOME

☐ Income ☐ Savings ☐ Family members

[Have you considered whether you could afford to keep this policy if the premiums were raised, for example, by 20%?]

Note: The insurer shall use the bracketed sentence unless the policy is fully paid up or is a noncancellable policy.

What is your annual income? (check one)

☐ Under $10,000 ☐ $10,000−20,000 ☐ $20,000−30,000 ☐ $30,000−50,000 ☐ Over $50,000

Note: The insurer may choose the numbers to put in the brackets to fit its suitability standards.

How do you expect your income to change over the next 10 years? (check one)

☐ No change ☐ Increase ☐ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) ☐ Yes ☐ No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

☐ From my Income ☐ From my Savings \ Investments ☐ My Family will Pay

The national average annual cost of care in [insert year] was [insert $ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert $ amount] if costs increase 5% annually.

What elimination period are you considering? Number of days _____Approximate cost $ _____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

☐ From my Income ☐ From my Savings \ Investments ☐ My Family will Pay

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QUESTIONS RELATED TO YOUR SAVINGS AND INVESTMENTS

Not counting your home, what is the approximate value of all of your assets (savings and investments)? (check one)

☐ Under $20,000 ☐ $20,000−$30,000 ☐ $30,000−$50,000 ☐ Over $50,000

How do you expect your assets to change over the next ten years? (check one)

☐ Stay about the same ☐ Increase ☐ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long−term care.

DISCLOSURE STATEMENT

☐ The answers to the questions above describe my financial situation.

or

☐ I choose not to complete this information.

(Check one.)

☐ I acknowledge that the carrier or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. I understand that the rates for this policy may increase in the future. (This box shall be checked).

Signed:_____ _____

(Applicant) (Date)

(I explained to the applicant the importance of completing this information.)

Signed:_____ _____

(Agent) (Date)

Agent's Printed Name:_____

Note: In order for us to process your application, please return this signed statement to [name of company], along with your application.

[My agent has advised me that this policy does not appear to be suitable for me. However, I still want the company to consider my application.]

Signed:_____ _____

(Applicant) (Date)

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Ins 3.46 APPENDIX 3

THINGS YOU SHOULD KNOW BEFORE YOU BUY LONG−TERM CARE INSURANCE

Long−Term Care Insurance	▪	A long−term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
	▪	[You should not buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]

[Note: For single premium policies, delete the above bullet; for noncancellable policies, delete the second sentence only.]

	▪	The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.
Medicare	▪	Medicare does not pay for most long−term care.
Medicaid	▪	Medicaid will generally pay for long−term care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid.
	▪	Many people become eligible for Medicaid after they have used up their own financial resources by paying for long−term care services.
	▪	When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
	▪	Your choice of long−term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.
Shopper's Guide	▪	Make sure the insurance company or agent gives you a copy of a booklet called the "Guide to Long−Term Care." Read it carefully. If you have decided to apply for long−term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.
Counseling	▪	Free counseling and additional information about long−term care insurance are available through your state's insurance counseling program. Contact your state department on aging for more information about the senior health insurance counseling program in your state.
Facilities	▪	Some long−term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move to a different state from where they purchased their long−term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

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Ins 3.46 APPENDIX 4

LONG−TERM CARE INSURANCE SUITABILITY LETTER

Dear [Applicant]:

Your recent application for [long−term care insurance] [insurance for care in a nursing home] [insurance for care at home or other community setting] included a "personal worksheet," which asked questions about your finances and your reasons for buying this coverage. For your protection, state law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that insurance coverage you applied for may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Guide to Long−Term Care" and the page titled "Things You Should Know Before Buying Long−Term Care Insurance." The Wisconsin Office of the Commissioner of Insurance also has information about long−term care insurance and may be able to refer you to a county Benefit specialist or a Senior Health Insurance Information specialist free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

Note: Choose the paragraph and bracketed sentences in that paragraph that apply.

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application, and issue you a policy.

Please check one box and return in the enclosed envelope.

☐ Yes, [although my worksheet indicates that nursing home only or home health care insurance only insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

Note: Delete the phrase in brackets if the applicant did not answer the questions about income.

☐ No, I have decided not to buy a policy at this time.

_____ _____

(Applicant's Signature) (Date)

Please return to [insurer] at [address] by [date].

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Ins 3.46 APPENDIX 5

LONG−TERM CARE INSURANCE POTENTIAL RATE INCREASE DISCLOSURE FORM

Instructions:

This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

Insurers shall provide all of the following information to the applicant:

1. [Premium Rate] [Premium Rate Schedules]: [Premium rate] [Premium rate schedules] that [is][are] applicable to you and that will be in effect until a request is made and [filed] for an increase [is][are] [on the application][$_____])

2. The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.

3. Rate Schedule Adjustments:

   The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): _____.

4. Potential Rate Revisions:

This policy is Guaranteed Renewable. This means that the rates for this policy may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

- Pay the increased premium and continue your policy in force as is.
- Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
- Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

*Contingent Nonforfeiture

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long−term care insurance coverage, if:

Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table and

You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option your policy with this reduced maximum benefit amount will be considered paid up with no further premiums due.

Example:

You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.

In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).

Your paid−up policy benefits are $10,000 (provided you have at least $10,000 of benefits remaining under your policy.)

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Contingent Nonforfeiture
Cumulative Premium Increase Over Initial Premium
That Qualifies For Contingent Nonforfeiture

(Percentage increase is cumulative from date of original issue. It does NOT represent a one−time increase.)

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30−34	190%
35−39	170%
40−44	150%
45−49	130%
50−54	110%
55−59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

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[The following contingent nonforfeiture disclosure need only be included for those limited pay policies to which sub. (19) (j) is applicable.]

In addition to the contingent nonforfeiture benefits described above, the following reduced "paid−up" contingent nonforfeiture benefit is an option in all policies that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit when you bought your policy. If both the reduced "paid up" benefit AND the contingent benefit described above are triggered by the same rate increase, you can choose either of the two benefits.

You are eligible for the reduced "paid up" contingent nonforfeiture benefit when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below;

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65−80	30%
Over 80	10%

2. You stop paying your premiums within 120 days of when the premium increase took effect; AND

3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

   If you exercise this option, your coverage will be converted to reduced "paid−up" status. That means there will be no additional premiums required. Your benefits will change in the following ways:

   a. The total lifetime amount of benefits your reduced paid up policy will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the policy becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.

   b. The daily benefit amounts you purchased will also be adjusted by the same ratio.

If you purchased lifetime benefits, only the daily benefit amounts you purchased will be adjusted by the applicable ratio.

Example:

- You bought the policy at age 65 with an annual premium payable for 10 years.
- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.
- Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your "paid−up" policy benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced "paid−up" policy.

Removed by Register December 2010 No. 660. For current adm. code see: http://docs.legis.wisconsin.gov/code/admin_code.

Ins 3.46 APPENDIX 6

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG−TERM CARE INSURANCE

[Insurance company's name and address]

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

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long−term care insurance and replace it with an individual long−term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long−term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long−term care coverage is a wise decision.

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

(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions that you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long−term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

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

_____

(Signature of Agent, Broker or Other Representative)

[Typed Name and Address of Agent or Broker]

The above "Notice to Applicant" was delivered to me on:

_____ _____

(Applicant's Signature) (Date)

Removed by Register December 2010 No. 660. For current adm. code see: http://docs.legis.wisconsin.gov/code/admin_code.

Ins 3.46 APPENDIX 7

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG−TERM CARE INSURANCE

[Insurance company's name and address]

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

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long−term care insurance and replace it with the long−term care insurance policy delivered herewith issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long−term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long−term care coverage is a wise decision.

1. Health conditions that you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long−term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

[Company Name]

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Ins 3.46 APPENDIX 8

RESCISSION REPORTING FORM FOR LONG−TERM CARE POLICIES

FOR THE STATE OF _____

FOR THE REPORTING YEAR [ ]

Company Name: _____

Address: _____

_____

Phone Number: _____

Due: March 1 annually

INSTRUCTIONS:

The purpose of this form is to report all rescissions of long−term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy Form #	Policy and Certificate #	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Rescission

Detailed reason for rescission:

_____

_____

_____

_____

_____

_____

Signature

_____

Name and Title (please type)

_____

Date

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Ins 3.46 APPENDIX 9

CLAIMS DENIAL REPORTING FORM
LONG−TERM CARE INSURANCE

For the State of _____

For the Reporting Year of _____

Company Name: _____

Due: June 30 annually

Company Address:

_____

_____

Company NAIC Number: _____

Contact Person: _____Phone Number: _____

Line of Business: Individual Group

INSTRUCTIONS

The purpose of this form is to report all long−term care claim denials under in force long−term care insurance policies. "Denied" means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

		State Data	Nationwide Data[1]
1	Total Number of Long−Term Care Claims Reported		
2	Total Number of Long−Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid due to Waiting (Elimination) Period Not Met		
5	Net Number of Long−Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)		
6	Percentage of Long−Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1)		
7	Number of Long−Term Care Claim Denied due to:		
8	Long−Term Care Services Not Covered under the Policy[2]		
9	Provider/Facility Not Qualified under the Policy[3]		
10	Benefit Eligibility Criteria Not Met[4]		
11	Other		

[1] The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.

[2] Example—home health care claim filed under a nursing home only policy.

[3] Example—a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.

[4] Examples—a benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

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INS 3.46 Appendix 10

LONG−TERM CARE INSURANCE

REPLACEMENT AND LAPSE REPORTING FORM

For the State of _____

For the Reporting Year of _____

Company Name: _____

Due: June 30 annually

Company Address: _____

Company NAIC Number: _____

Contact Person: _____

Phone Number: (____) _____

INSTRUCTIONS:

The purpose of this form is to report on a statewide basis information regarding long−term care insurance policy replacements and lapses. Specifically, every insurer shall maintain records for each agent on that agent's amount of long−term care insurance replacement sales as a percent of the agent's total annual sales and the amount of lapses of long−term care insurance policies sold by the agent as a percent of the agent's total annual sales. The tables below should be used to report the ten percent (10%) of the insurer's agents with the greatest percentages of replacements and lapses.

Listing of the 10% of Agents with the Greatest Percentage of Replacements

Agent's Name	Number of Policies Sold By This Agent	Number of Policies Replaced By This Agent	Number of Replacements As % of Number Sold By This Agent

Listing of the 10% of Agents with the Greatest Percentage of Lapses

Agent's Name	Number of Policies Sold By This Agent	Number of Policies Lapsed By This Agent	Number of Lapses As % of Number Sold By This Agent

Company Totals

Percentage of Replacement Policies Sold to Total Annual Sales ____%

Percentage of Replacement Policies Sold to Policies In Force (as of the end of the preceding calendar year) ____%

Percentage of Lapsed Policies to Total Annual Sales _____%

Percentage of Lapsed Policies to Policies In Force (as of the end of the preceding calendar year) ____%

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Ins 3.465 Wisconsin long−term care partnership program. (1) GENERAL APPLICABILITY. The provisions within s. Ins 3.46 regarding insurance transactions for long−term care and life insurance policies with long−term care provisions apply to insurance transactions described within this section.

(2) DEFINITIONS. The definitions contained in ss. Ins 3.455 and 3.46 also apply in this section. In addition, the following definitions apply in this section:

(a) "Automatic exchange" means the issuance of a notice from an insurer informing an existing insured that the policy the insured purchased prior to January 1, 2009, from the insurer has been approved by the commissioner as a policy that meets the requirements of the state's partnership program and, as such, the policy will be treated from the date of the notice as a qualifying partnership policy.

(b) "Consumer price index" means the consumer price index for all urban consumers, U.S. city average, all items, as determined by the Bureau of Labor Statistics of the United States Department of Labor.

(c) "Qualified long−term care insurance contract" or "federally tax−qualified long−term care insurance contract" means an individual or group insurance long−term care, nursing home or home health care contract that meets the requirements of section 7702B(b) of the Internal Revenue Code of 1986, as amended, or the portion of a life insurance contract that provides long−term care insurance coverage by rider or as part of the contract and that satisfies the requirements of sections 7702B(b) and (c) of the Internal Revenue Code of 1986, as amended.

(d) "Qualifying partnership policy exchange" means the exchange of an existing long−term care insurance plan with an identical policy that on or after January 1, 2009 is certified by the insurer to meet the federal requirements established for the state's partnership program or the exchange of an existing long−term care insurance policy with an identical policy except for the addition of a benefit or rider that, on or after January 1, 2009, is certified by the insurer to meet the federal requirements established for the state's partnership program.

(e) "Secretary" means the U. S. Secretary of the Department of Health and Human Services.

(3) QUALIFYING PARTNERSHIP POLICIES. (a) This section applies to an insurer offering a long−term care policy that is intended to qualify an insured under the state's partnership program and that is in compliance with the requirements of 42 U.S.C 1396p (b).

(b) In order for a long−term care policy to qualify as a qualifying partnership policy, the policy shall comply with the requirements set forth in s. 49.45 (31), Stats., and the all of the following:

1. Be filed with and approved by the commissioner prior to use and contain the certification referenced in sub. (5) (a), and comply with s. 631.28, Stats.

2. Meet the requirements of a tax−qualified long−term care insurance contract as defined in section 7702B(b) of the Internal Revenue Code of 1986, as amended.

3. Meet all applicable requirements of this section and ss. Ins 3.455 and 3.46.

4. Be accompanied by a clear disclosure that the policy is intended to be a qualifying partnership policy. The disclosure shall be in the format contained in Appendix 1.

5. Provide inflation protection provisions in compliance with sub. (5).

6. Not base underwriting criteria upon whether or not the policy is a qualifying partnership policy.

(4) FORM REQUIREMENTS FOR QUALIFYING PARTNERSHIP POLICIES. An insurer that offers a long−term care insurance policy that is intended to qualify an insured under the state's partnership program shall comply with all of the following:

(a) File the policy, outline of coverage, premium rates, and actuarial memorandum to the commissioner in accordance with s. 631.20, Stats., and s. Ins 3.455, and include the qualifying partnership policy certification form.

Note: The qualifying partnership policy certification form (OCI No. 26−113) can be obtained from the Office of the Commissioner of Insurance at no cost from the OCI website www.oci.wi.gov or by writing to the State of Wisconsin Office of the Commissioner of Insurance 125 S. Webster, Madison, WI 53703.

(b) Submit the qualifying partnership policy certification form to the commissioner, prior to use, for approval if an insurer intends to use a previously approved policy to qualify as a qualifying partnership policy.

(c) File the endorsement or rider and submit the qualifying partnership policy certification form to the commissioner, prior to use, for approval if the insurer intends to amend a previously approved policy with an endorsement or rider, as needed, to qualify the policy as a qualifying partnership policy.

(d) Certification shall be in the format specified by the commissioner and identified as OCI No. 26−113, and comply with the following:

1. The certification shall be made and signed by an officer of the insurer having the authority to bind the insurer and shall include full contact information for the certifying officer.

2. The certification for pars. (b) and (c) shall identify the policy by the original form number and approval date.

(5) INFLATION PROTECTION REQUIREMENTS. An insurer offering a long−term care insurance policy that is intended to qualify an insured under the state partnership program shall comply with the following inflation protection provisions.

(a) For a person who is less than 61 years of age as of the date of purchase of the policy, the policy shall provide compound annual inflation protection that complies with one of the following:

1. Provide and maintain a level premium that contains automatic annual compounded inflation increases at a rate that is at least 3%.

2. Provide and maintain a level premium that contains automatic annual compounded inflation increases at a rate based on changes in the consumer price index.

3. Provide for annual compounded inflation increases at a rate that is at least 3% and meet all of the following requirements:

a. Each benefit increase occurs automatically, unless the insured specifically rejects an increase.

b. The increases shall be provided until the insured has at least attained age 76 and each increase up to and including the increase that takes effect at age 76 may not be rejected by the insured in order to retain qualifying partnership policy status.

c. Increases may end when the insured has attained age 76, rejected an offer of inflation increase, or becomes eligible for benefits on or after age 76.

d. The additional premium for each increase under this feature may be based on the premium rates that apply to the insured's attained age at the time of the increase.

e. Rejection of an increase may not limit the coverage under the policy, except for the asset disregard feature of a qualified partnership policy, and from the insured receiving future premium increases as contemplated in s. Ins 3.455.

(b) For a person who is at least 61 years of age but less than 76 years of age as of the date of purchase of the policy, the policy shall provide inflation protection that meets the requirements of par. (a) or an inflation protection feature that provides at least 3% annual simple inflation protection.

(c) For a person who is at least 76 years of age as of the date of purchase of the policy, the policy may provide inflation protection with terms no less restrictive than those identified in pars. (a) and (b), but inflation protection is not required.

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(6) DISCLOSURE WHEN SOLICITING. In addition to the requirements of s. Ins 3.46, an insurer issuing or marketing a policy that is intended to qualify an insured for the state's partnership program shall explain at the time of solicitation the benefits associated with a qualifying partnership policy and comply with all of the following:

(a) 1. An insurer or its intermediary shall provide to each prospective applicant all of the following:

a. Qualifying partnership policy notices in the format contained in Appendix 1 and 2.

b. The Guide to Long−term Care booklet.

c. The Wisconsin Long−term Care Programs guide.

2. No insurer or intermediary shall be responsible for providing applicants the revised guides until 90 days after the insurer or intermediary has been given notice that the revised guides are available.

(b) For a qualifying partnership policy issued to a group when an outline of coverage is not delivered, the insurer or intermediary shall deliver copies of the qualifying partnership policy disclosure notice, The Guide to Long−term Care booklet, and The Wisconsin Long−term Care Programs guide.

(c) For a life insurance policy that offers long−term care insurance as a provision in the policy or in a rider that is intended to qualify an insured under the state's partnership program, the insurer or intermediary at the time of solicitation shall deliver the disclosure notice (Appendix 1), the Guide to Long−term Care booklet, and the Wisconsin Long−term Care Programs guide.

(7) OTHER DISCLOSURES. (a) When an insurer is made aware that the insured or certificateholder initiated a policy change request or declined a benefit increase that will result in the loss of the status as a qualifying partnership policy, the insurer shall provide, in writing, an explanation of how such action impacts the insured. The insurer shall also advise the insured or certificateholder of how to retain the policy as a qualified partnership policy, if requested.

(b) If a qualifying partnership policy no longer meets the requirements of the state's partnership program, the insurer shall explain, in writing, to the policyholder or certificateholder the reason for the loss of status.

(c) The insurer shall provide a completed qualifying partnership policy summary document in the format of OCI No. 26−114, when requested by the insured or the insured's authorized representative.

(8) EXCHANGE OF LONG−TERM CARE INSURANCE POLICY TO A QUALIFYING PARTNERSHIP POLICY. (a) *Restrictions on exchange.* 1. Insurers offering long−term care policies that are intended to qualify an insured under the state's partnership program are subject to s. Ins 3.455 (9m).

2. Insurers issuing an automatic exchange shall comply with all of the following:

a. Only a policy that requires no modifications or additions is eligible for an automatic exchange.

b. The new policy may not be underwritten.

c. The rate used in determining the premium charged for the new policy shall be determined using the original issue age and risk class of the insured that was used to determine the rate of the existing policy and may not contemplate that the new policy is a qualified partnership policy.

d. Insurers issuing automatic exchanges shall provide insureds, at the time of notice of the automatic exchange, a copy of Appendix 1, the Guide to Long−Term Care booklet and the Wisconsin Long−Term Care Programs guide. After issuance of the notice for automatic exchange, if the insured does not decline the offer, the insurer shall provide the insured a copy of Appendix 2.

e. Insurers issuing an automatic exchange shall offer to the insured, at the time of notice of the automatic exchange, the option to decline the automatic exchange and retain the existing policy if the insured responds within a period of time not less than 120 days.

3. An insurer offering an exchange as to a qualifying partnership policy with an actuarial value of benefits exceeding the actuarial value of benefits of the existing policy shall be subject to all of the following:

a. The insurer shall treat the exchange as a replacement and comply with s. Ins 3.46, including suitability.

b. The insurer shall apply its new business long−term care underwriting guidelines to the increased benefits only.

c. The premium charged for the new policy shall be determined using the method in subd. 3. for existing benefits and the rate for the additional benefits using the then current age and risk class of the insured for the additional benefits only.

4. An insurer shall maintain documentation of the actuarial value analysis determination and shall provide the analysis to the commissioner upon request.

(b) *Offer of exchange.* An insurer that submits and receives approval to offer a long−term care insurance policy that is intended to be a qualifying partnership policy in this state may, subject to the following requirements, offer an exchange:

1. Within one year from the date the insurer begins to advertise, market, offer, sell, or issue policies that are intended to be qualifying partnership policies, on a one−time basis in writing, offer to all existing policyholders or certificateholders that were issued long−term care coverage by the insurer with an issue date on or after February 8, 2006, the option to exchange their existing long−term care policy for a qualifying partnership policy. Insurers may offer the exchange option to policyholders or certificateholders with long−term care policies issued prior to February 8, 2006, pursuant to a plan filed with the commissioner.

2. The offer shall be made on a nondiscriminatory basis without regard to the age or health status of the insured.

3. The offer shall remain open for a minimum of 120 days from the date of the mailing by the insurer.

4. The effective date of the partnership plan policy shall be the date of the exchanged policy.

5. In the event of an exchange, the insured may not lose any rights that have accrued under the original policy including, but not limited to, rights established because of the lapse of time related to pre−existing condition exclusions, elimination periods, or incontestability clauses.

6. The written offer to exchange shall include the disclosure form contained in Appendix 2 and also shall include the Guide to Long−Term Care booklet and the Wisconsin Long−Term Care Programs guide. The insurer shall file with the commissioner, prior to use and for informational purposes, the exchange letter to be used in the exchange offer.

(c) *Exchanged policy requirements.* 1. The new policy offered in an exchange or automatic exchange shall be of a form that is offered for sale by the insurer in the general market at the time of exchange.

2. A policy received in an exchange on or after January 1, 2009, is treated as newly issued and thus is eligible for partnership program status. For purposes of applying the Medicaid rules relating to the state partnership program, the addition of a rider, endorsement, or change in schedule page for a policy may be treated as giving rise to an exchange.

(d) *Exceptions and exemptions.* 1. Insurers offering group long−term care policies are exempt from subs. (5) to (7) and (8) (a) to (c), if they comply with all of the following:

a. The policy is issued to a local, municipal, county, or state public employee group.

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b. The group coverage was negotiated as part of a collective bargaining agreement.

c. The group coverage is provided to all eligible employees on a guaranteed issue basis.

d. The policy provides insureds with at least 5% compound annualized inflation protection.

e. The policy meets the requirements of subs. (3) and (4).

f. No later than one year from the date the insurer begins to advertise, market, offer, sell, or issue policies that are intended to be qualifying partnership policies, the insurer shall provide notice that the policy meets the requirements of a qualifying partnership plan and shall provide the insureds with Appendix 1, the Guide to Long−Term Care booklet and the Wisconsin Long−Term Care Programs guide. The insurer shall file with the commissioner, prior to use and for informational purposes, the exchange letter to be used in the exchange offer.

g. To accomplish an automatic exchange the insurer shall apply the exchange to all group members.

h. The effective date of the qualifying partnership policy shall be the date of the exchanged policy.

i. In the event of an exchange, the insured and its certificateholders may not lose any rights that have accrued under the original policy including, but not limited to, rights established because of the lapse of time related to pre−existing condition exclusions, elimination periods, or incontestability clauses.

2. Notwithstanding par. (b), an insurer is not required to offer an exchange to an individual who is eligible for benefits or within an elimination period or who is, or who has been in, claim status on or after January 1, 2009, or who would not be eligible to apply for coverage due to issue age limitations under the new policy. The insurer may require that policyholders or certificateholders meet all eligibility requirements, including plan design, underwriting, if applicable, and payment of the required premium.

History: EmR0817: emerg. cr. eff. 6−3−08; CR 08−032: cr. Register October 2008 No. 634, eff. 11−1−08.

Note: CR 08−032 first applies to policies or certificates issued on or after January 1, 2009 or on the first renewal date on or after January 1, 2009, but no later than January 1, 2010 for collectively bargained policies or certificates.

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Ins 3.465 APPENDIX 1

PARTNERSHIP POLICY STATUS DISCLOSURE NOTICE

Important Notice Regarding Your Policy's Long−Term Care Insurance Partnership Plan Status

(Please Keep This Notice With Your Policy or Certificate)

The Wisconsin Long−Term Care Insurance Partnership Program (Wisconsin Partnership Program) is a partnership between the State of Wisconsin and private insurers of long−term care insurance policies [certificates]. The Wisconsin Partnership Program became effective on January 1, 2009. This Notice explains the Medicaid asset protection that you may receive being insured under a Partnership Policy [Certificate].

Notice of Partnership Plan Policy Status. Your long−term care insurance policy [certificate] is intended to qualify as a Qualifying Partnership Policy [Certificate] under the Wisconsin Long−Term Care Insurance Partnership Program as of your policy's [certificate's] effective date.

You should also be aware that insurers are required to provide personally identifying information, including your name, to the federal government to be entered into a federal data base to which state Medicaid departments will have access.

Medicaid Asset Protection Provided by the State Medicaid Program. Long−term care insurance is one tool that helps individuals prepare for future long−term care needs. **The purchase of a Qualifying Partnership Policy [certificate] does not automatically qualify you for Medicaid.**

In particular, such policies [certificates] may permit individuals to protect assets from spend−down requirements under Wisconsin's Medicaid program if assistance under this program is ever needed and you otherwise qualify for Medicaid.

Specifically, the asset eligibility and recovery provisions of the Wisconsin Medicaid program are applied by disregarding the amount of assets equal to the amount of insurance benefits you have received from your Qualifying Partnership Policy [Certificate]. The disregarded assets are also exempt from estate recovery. For example, if you receive $200,000 of insurance benefits from your Qualifying Partnership Policy [Certificate], you generally would be able to retain $200,000 of assets above and beyond the amount of assets normally permitted for Medicaid eligibility.

Other Medicaid eligibility requirements apart from permissible assets shall be met, including special rules that may apply if the equity in your home exceeds [$750,000]. In addition, you shall meet the Medicaid program's income requirements and may be required to contribute some of your income to the costs of your care once you become eligible for Medicaid. Medicaid eligibility requirements may vary by county and may change over time. Medicaid eligibility requirements may also be different from state to state.

Additional Consumer Protections. In addition to providing Medicaid asset protection, your Partnership Policy [Certificate] has other important features. Under the rules governing Wisconsin's Long−Term Care Insurance Partnership Program, your Qualifying Partnership Policy [Certificate] shall be a tax−qualified long−term care insurance contract under Federal tax law, and as such the insurance benefits you receive from the policy generally will not be subject to income tax. (Please note that a policy or certificate can be a qualified long−term care insurance contract under Federal and State income tax law, with the same income tax treatment, even if it is not a Qualifying Partnership Policy [Certificate].) In addition, if you were under age 76 when you purchased your Qualifying Partnership Policy [Certificate], it shall provide inflation protection to help protect against potential future increases in the cost of long−term care. (For older purchasers, only an offer of inflation protection is required.)

What Could Disqualify Your Policy as a Partnership Policy [Certificate]. If you make any changes to your policy or certificate, such changes could affect whether your policy [certificate] continues to be a Qualifying Partnership Policy [Certificate]. Before you make any changes, you should consult with the [carrier's name] to determine the effect of a proposed change. In addition, if you move to a state that does not maintain a Partnership Program or does not recognize your policy as a Qualifying Partnership Policy [Certificate], you would not receive Medicaid asset protection in that state. However, the coverage contained in your policy would not be affected. Also, changes in Federal or State law could modify, reduce or eliminate the Medicaid asset protection available with respect to your Qualifying Partnership Policy [Certificate] after you have purchased the policy.

Additional information. If you would like further information about the Medicaid asset protection provided by your Qualifying Partnership Policy [Certificate] or the Wisconsin's Long−Term Care Insurance Partnership Program, please contact State of Wisconsin Member Services at 1−800−362−3002.

Removed by Register December 2010 No. 660. For current adm. code see: http://docs.legis.wisconsin.gov/code/admin_code.

Ins 3.465 APPENDIX 2

PARTNERSHIP PROGRAM NOTICE

Important Consumer Information Regarding the Wisconsin Long−Term Care Insurance Partnership Program

Some long−term care insurance policies [certificates] sold in Wisconsin may qualify for the Wisconsin Long−Term Care Insurance Partnership Program (the Partnership Program). The Partnership Program is a partnership between state government and private insurance companies to assist individuals in planning their long−term care needs. Insurance companies voluntarily agree to participate in the Partnership Program by offering long−term care insurance coverage that meets certain State and Federal requirements. Long−term care insurance policies [certificates] that qualify as Qualifying Partnership Policies [Certificates] may protect the policyholder's [certificateholder's] assets through a feature known as "Asset Disregard" under Wisconsin's Medicaid program.

Asset Disregard means that amount of the policyholder's [certificateholder's] assets equal to the amount of long−term care insurance benefits received under a Qualifying Partnership Policy [Certificate] will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a Qualifying Partnership Policy [Certificate] without affecting the person's eligibility for Medicaid. The disregarded assets are also exempt from estate recovery. All other Medicaid eligibility criteria will apply and special rules may apply to persons whose home equity exceeds $750,000. Asset Disregard is available under a Qualifying Partnership Policy [Certificate]. Therefore, you should consider if Asset Disregard is important to you, and whether a Qualifying Partnership Policy meets your needs. The purchase of a Qualifying Partnership Policy does not automatically qualify you for Medicaid.

What are the Requirements for a Partnership Policy [Certificate]? In order for a policy [certificate] to qualify as a Qualifying Partnership Policy [Certificate], it shall, among other requirements:

- Have an effective date on or after January 1, 2009;
- Be issued to an individual who was a Wisconsin resident when coverage first becomes effective under the policy;
- Be a tax−qualified policy under s. 7702(B)(b) of the Internal Revenue Code of 1986, as amended;
- Meet certain consumer protection standards; and,
- Meet the following inflation requirements:
  - For persons age 60 or younger – provide compound annual inflation protection of at least 3%.
  - For persons age 61−75 – provide annual inflation protection of at least 3% not compounded.
  - For persons age 76 and older – there are no requirements for purchasing inflation protection.

If you apply and are approved for long−term care insurance coverage, [carrier name] will provide you with written documentation as to whether or not your policy [certificate] is a Qualifying Partnership Policy.

You should also be aware that insurers are required to provide personally identifying information, including your name, to the federal government to be entered into a federal data base to which state Medicaid departments will have access.

What Could Disqualify a Policy [Certificate] from Continuing to be a Qualifying Partnership Policy? Certain types of changes to a Qualifying Partnership Policy [Certificate] could affect whether or not such policy [certificate]continues to be a Qualifying Partnership Policy [Certificate]. If you purchase a Qualifying Partnership Policy [Certificate] and later decide to make a change, you should first consult with [carrier name] to determine the effect of the proposed changes. In addition, if you move to a state that does not maintain a Partnership Program or does not recognize your policy [certificate] as a Qualifying Partnership Policy [Certificate], you would not receive treatment of you policy [certificate] under the Medicaid program of that state. However, the coverage under your policy will not be affected. The information contained in this disclosure is based upon current Wisconsin and Federal laws. These laws may be subject to change. Any change in law could modify, reduce or eliminate the treatment of your policy [certificate] under Wisconsin's Medicaid program.

Additional Information: If you have questions regarding long−term care insurance policies [certificates] please contact [carrier name]. If you have questions regarding current laws governing Wisconsin Medicaid eligibility, you should contact State of Wisconsin Member Services at 1−800−362−3002.

Removed by Register December 2010 No. 660. For current adm. code see: http://docs.legis.wisconsin.gov/code/admin_code.

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), Stats., and would result in misrepresentation as defined and prohibited in s. 628.34 (1), Stats.

(2) PURPOSE. This section interprets s. 628.34 (12), Stats., relating to unfair trade practices. It requires insurers and intermediaries who sell cancer insurance to give all prospective buyers of cancer insurance a shopper's guide prepared by the national association of insurance commissioners.

(3) SCOPE. This section applies to all individual, group and franchise insurance policies or riders which provide benefits for or are advertised as providing benefits primarily for the treatment of cancer. This section 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. "A Shopper's Guide to Cancer Insurance" means the document which contains the language set forth in Appendix I to this section.

(5) DISCLOSURE REQUIREMENTS. (a) Each insurer offering a policy or rider described in sub. (3) shall print, and the insurer and its intermediaries shall provide to all prospective purchasers of any policy or rider subject to this section, a copy of "A Shopper's Guide to Cancer Insurance" at the time the prospect is contacted by the insurer or intermediary with an invitation to apply, as defined in s. Ins 3.27 (5) (g).

(b) "A Shopper's Guide to Cancer Insurance" shall be printed in an easy−to−read type of not less than 12−pt. size.

History: Cr. Register, June, 1981, No. 306, eff. 8−1−81; am. (2) to (5), r. (6), r. and recr. Appendix, Register, September, 1990, No. 417, eff. 10−1−90.

Removed by Register December 2010 No. 660. For current adm. code see: http://docs.legis.wisconsin.gov/code/admin_code.

Ins 3.47 APPENDIX I

A SHOPPER'S GUIDE TO CANCER INSURANCE

Should You Buy Cancer Insurance?

Cancer Insurance is Not a Substitute for Comprehensive Coverage.

Caution: Limitations On Cancer Insurance.

Prepared by the National Association of Insurance Commissioners

CANCER INSURANCE . . .

Cancer insurance provides benefits only if you get cancer. No policy will cover cancer diagnosed before you applied for the policy. Examples of other specified disease policies are heart attack or stroke policies. The information in this booklet applies to cancer insurance, but could very well apply to other specified disease policies.

CANCER INSURANCE IS NOT A SUBSTITUTE FOR COMPREHENSIVE COVERAGE . . .

Cancer treatment accounts for about 10% of U.S. health expenses. In fact, no single disease accounts for more than a small proportion of the American public's health care bill. This is why it is essential to have insurance coverage for all conditions, not just cancer.

If you and your family are not protected against catastrophic medical costs, you should consider a major medical policy. These policies pay a large percentage of your covered costs after a deductible is paid either by you or your basic insurance. They often have very high maximums, such as $100,000 to $1,000,000. Major medical policies will cover you for any accident or sickness, including cancer. They cost more than cancer policies because they cover more, but they are generally considered a better buy.

SHOULD YOU BUY CANCER INSURANCE? . . . MANY PEOPLE DON'T NEED IT

If you are considering cancer insurance, ask yourself three questions: Is my current coverage adequate for these costs? How much will the treatment cost if I do get cancer? How likely am I to contract the disease?

If you have Medicare and want more insurance, a comprehensive Medicare supplement policy is what you need.

Low income people who are Medicaid recipients don't need any more insurance. If you think you might qualify, contact your local social service agency.

Duplicate Coverage is Expensive and Unnecessary. Buy basic coverage first such as a major medical policy. Make sure any cancer policy will meet needs not met by your basic insurance. You cannot assume that double coverage will result in double benefits. Many cancer policies advertise that they will pay benefits no matter what your other insurance pays. However, your basic policy may contain a coordination of benefits clause. That means it will not pay duplicate benefits. To find out if you can get benefits from both policies, check your regular insurance as well as the cancer policy.

Some Cancer Expenses May Not Be Covered Even by a Cancer Policy. Medical costs of cancer treatment vary. On the average, hospitalization accounts for 78% of such costs and physician services make up 13%. The remainder goes for other professional services, drugs and nursing home care. Cancer patients often face large nonmedical expenses which are not usually covered by cancer insurance. Examples are home care, transportation and rehabilitation costs.

Don't be Misled by Emotions. While three in ten Americans will get cancer over a lifetime, seven in ten will not. In any one year, only one American in 250 will get cancer. The odds are against your receiving any benefits from a cancer policy. Be sure you know what conditions must be met before the policy will start to pay your bills.

CAUTION: LIMITATIONS OF CANCER INSURANCE

Cancer policies sold today vary widely in cost and coverage. If you decide to purchase a cancer policy, contact different companies and agents, and compare the policies before you buy. Here are some common limitations:

Some policies pay only for hospital care. Today cancer care treatment, including radiation, chemotherapy and some surgery, is often given on an outpatient basis. Because the average stay in the hospital for a cancer patient is only 13 days, a policy which pays only when you are hospitalized has limited value.

Many policies promise to increase benefits after a patient has been in the hospital for 90 consecutive days. However, since the average stay in a hospital for a cancer patient is 13 days, large dollar amounts for extended benefits have very little value for most patients.

Many cancer insurance policies have fixed dollar limits. For example, a policy might pay only up to $1,500 for surgery costs or $1,000 for radiation therapy, or it may have fixed payments such as $50 or $100 for each day in the hospital. Others limit total benefits to a fixed amount such as $5,000 or $10,000.

No policy will cover cancer diagnosed before you applied for the policy. Some policies will deny coverage if you are later found to have had cancer at the time of purchase, even if you did not know it.

Most cancer insurance does not cover cancer−related illnesses. Cancer or its treatment may lead to other physical problems, such as infection, diabetes or pneumonia.

Many policies contain time limits. Some policies require waiting periods of 30 days or even several months before you are covered. Others stop paying benefits after a fixed period of two or three years.:

FOR ADDITIONAL HELP . . .

If you are considering a cancer policy, the company or agent should answer your questions. You do not need to make a decision to purchase the policy the same day you talk to the agent. Be sure to ask how long you have to make your decision. If you do not get the information you want, call or write

Office of the Commissioner of Insurance
121 East Wilson Street
P.O. Box 7873
Madison, WI 53707−7873
(608) 266−0103

If you have a complaint against an insurance company or agent, write the Office of the Commissioner of Insurance at the address above, or call the Complaints Hotline, 800−236−8517.

Removed by Register December 2010 No. 660. For current adm. code see: http://docs.legis.wisconsin.gov/code/admin_code.

Ins 3.49 Wisconsin automobile insurance plan. (1) PURPOSE. This section interprets s. 619.01 (6), Stats., to continue a plan to make automobile insurance available to those who are unable to obtain it in the voluntary market by providing for the equitable distribution of applicants among insurers and outlines access and grievance procedures for such a plan.

(2) DEFINITIONS. In this section:

(a) "Committee" means the governing committee of the Wisconsin Automobile Insurance Plan which is the group of companies administering the Plan.

(b) "Plan" means the Wisconsin Automobile Insurance Plan, an unincorporated facility established by s. 204.51, 1967 Stats., and continued under s. 619.01 (6), Stats.

(3) FILING AND ACCESS. The committee shall submit revisions to its rules, rates and forms for the Plan to the commissioner. Prior approval by the commissioner of the documents is required before they may become effective. The documents shall provide:

(a) Reasonable rules governing the equitable distribution of risks by direct insurance, reinsurance or otherwise and their assignment to insurers;

(b) Rates and rate modifications applicable to such risks which shall not be excessive, inadequate or unfairly discriminatory;

(c) The limits of liability which the insurer shall be required to assume;

(d) 1. A method by which an applicant to the Plan denied insurance or an insured under the Plan whose insurance is terminated may request the committee to review the denial or termination and by which an insurer subscribing to the Plan may request the committee to review actions or decisions of the Plan which adversely affect the insurer. The method shall specify that requests for review must be made in writing to the Plan and that the decision of the committee in regard to the review may be appealed by the applicant, insured or insurer to the commissioner of insurance as provided for in ch. Ins 5. A request for review does stay the termination of coverage.

2. The committee's decision under subd. 1. shall be in writing and shall include notice of the right to a hearing under ch. Ins 5 if the person files a petition for a hearing with the commissioner of insurance not later than 30 days after the notice is mailed. The notice shall describe the requirements of s. Ins 5.11 (1).

Note: A petition under subd. 2. shall be filed as provided in s. Ins 5.17.

3. The office of the commissioner of insurance shall hold a hearing within 30 days after receipt of a complete petition under subd. 2., unless the petitioner waives the right to a hearing within 30 days. At the hearing, the petitioner has the burden of proving by a preponderance of the evidence that the committee's decision is erroneous under the policy terms or the plan's rules.

4. Filing a petition under subd. 2. does not stay the action of the plan with respect to termination of coverage. The plan shall comply with the final decision and order in the contested case proceeding.

(e) The commissioner shall maintain files of the Plan's approved rules, rates, and forms and such documents must be made available for public inspection at the office of the commissioner of insurance.

History: Cr. Register, November, 1984, No. 347, eff. 12−1−84; renum. (3) (d) to be (3) (d) 1. and am., cr. (3) (d) 2. to 4., Register, March, 1996, No. 483, eff. 4−1−96.

Ins 3.51 Reports by individual practice associations. (1) DEFINITIONS. For the purpose of this section only:

(a) "Accountant" means an independent certified public accountant who is duly registered to practice and in good standing under the laws of this state or a state with similar licensing requirements.

(b) "Individual practice association" means an individual practice association as defined under s. 600.03 (23g), Stats., which contracts with a health maintenance organization insurer or a limited service health organization to provide health care services which are principally physician services.

(c) "Work papers" are the records kept by the accountant of the procedures followed, the tests performed, the information obtained, and conclusions reached pertinent to the examination of the financial statements of the independent practice association. Work papers include, but are not limited to, work programs, analysis, memorandum, letters of confirmation and representation, management letters, abstracts of company documents and schedules or commentaries prepared or obtained by the accountant in the course of the examination of the financial statements of the independent practice association and which support the accountant's opinion.

(2) FILING OF ANNUAL AUDITED FINANCIAL REPORTS. Unless otherwise ordered by the commissioner, an individual practice association shall file an annual audited financial report with the commissioner within 180 days after the end of each individual practice association's fiscal year. This section applies to individual practice associations for fiscal years terminating on or after March 31, 1991. The annual audited financial report shall report the assets, liabilities and net worth; the results of operations; and the changes in net worth for the fiscal year then ended on the accrual basis in conformity with generally accepted accounting practices. The annual audited financial report shall not be presented on the cash basis or the income tax basis or any other basis that does not fully account for all the independent practice association's liabilities incurred as of the end of the fiscal year. The annual audited financial report shall include all of the following:

(a) Report of independent certified public accountant.

(b) Balance sheet.

(c) Statement of gain or loss from operations.

(d) Statement of changes in financial position.

(e) Statement of changes in net worth.

(f) Notes to the financial statements. These notes shall include those needed for fair presentation and disclosure.

(g) Supplemental data and information which the commissioner may from time to time require to be disclosed.

(3) SCOPE OF AUDIT AND REPORT OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANT. Financial statements filed under sub. (2) shall be audited by an independent certified public accountant. The audit shall be conducted in accordance with generally accepted auditing standards. The commissioner may from time to time require that additional auditing procedures be observed by the accountant in the audit of the financial statements of the independent practice association under this rule.

(4) AVAILABILITY AND MAINTENANCE OF CPA WORK PAPERS. (a) An independent practice association required to file an audited financial report under this rule shall, if requested by the office, require the accountant to make available to the office all the work papers prepared in the conduct of the audit. The independent practice association shall require that the accountant retain the audit work papers for a period of not less than 5 years after the period reported.

(b) The office may photocopy pertinent audit work papers. These copies are part of the office's work papers. Audit work papers are confidential unless the commissioner determines disclosure is necessary to carry out the functions of the office.

(5) CONTRACTS. A health maintenance organization insurer contracting with an independent practice association shall include provisions in the contract which are necessary to enable the individual practice association to comply with this section including, but not limited to:

(a) Provisions providing for timely access to records;

(b) Provisions providing for maintenance of necessary records and systems and segregation of records, accounts and assets; and

(c) Other provisions necessary to ensure that the individual practice association operates as an entity distinct from the insurer.

History: Cr. Register, August, 1990, No. 416, eff. 9−1−90.

Removed by Register December 2010 No. 660. For current adm. code see: http://docs.legis.wisconsin.gov/code/admin_code.

Ins 3.53 HIV testing. (1) FINDINGS. The tests listed in sub. (4) (e) have been specified by the state epidemiologist in part B (4) of a report entitled "Validated positive, medically significant and sufficiently reliable tests to detect the presence of human immunodeficiency virus (HIV), antigen or nonantigenic products of HIV or an antibody to HIV," dated January 24, 1997. The commissioner of insurance, therefore, finds that these tests are sufficiently reliable for use in underwriting individual life, accident and health insurance policies.

(2) PURPOSES. The purposes of this section are:

(a) To implement s. 631.90 (3) (a), Stats.

(b) To establish procedures for insurers to use in obtaining informed consent for HIV testing and informing individuals of the results of a positive HIV test.

(c) To ensure the confidentiality of HIV test results.

(d) To restrict the use of certain information on HIV testing in underwriting group life, accident and health insurance policies.

(3) DEFINITIONS. In this section:

(a) "AIDS" means acquired immunodeficiency syndrome.

(b) "AIDS service organization" means a state designated organization in this state that provides AIDS prevention and education services to the general public and offers direct care and support services to persons with HIV and AIDS at no cost.

(c) "Health care provider" has the meaning given under s. 146.81 (1), Stats.

(d) "HIV" has the meaning given under s. 631.90 (1), Stats.

(e) "Medical information bureau, inc." means the nonprofit Delaware incorporated trade association, the members of which are life insurance companies, that operates an information exchange on behalf of its members.

(f) "State epidemiologist" has the meaning given under s. 252.01 (6), Stats.

(g) "Wisconsin AIDSline" means the state designated statewide AIDS information and medical referral service.

(4) TESTING; USE; PROHIBITIONS. (a) For use in underwriting an individual life, accident or health insurance policy, an insurer may require that the person to be insured be tested, at the insurer's expense, for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV.

(b) An insurer that requires a test under par. (a) shall, prior to testing, obtain a signed consent form, in substantially the format specified in Appendix A, either from the person to be tested or from one of the following if the specified condition exists:

1. The person's parent or guardian, if the person is under 14 years of age.

2. The person's guardian, if the person is adjudged incompetent under ch. 54, Stats.

3. The person's health care agent, as defined in s. 155.01 (4), Stats., if the person has been found to be incapacitated under s. 155.05 (2), Stats.

(c) The insurer shall provide a copy of the consent form to the person who signed it and shall maintain a copy of each consent form for at least one year.

(d) The insurer shall provide with the consent form a copy of the document, "Resources for persons with a positive HIV test/ The implications of testing positive for HIV." Each insurer shall either obtain copies of the document from the office of the commissioner of insurance or reproduce the document itself. If the document is revised, the insurer shall begin using the revised version no later than 30 days after receiving notice of the revision from the office of the commissioner of insurance.

Note: The document referred to in this paragraph is form number OCI 17−001. It may be obtained from the Office of the Commissioner of Insurance, P.O. Box 7873, Madison, Wisconsin 53707−7873.

(e) Tests may be used under par. (a) only if the tests meet the following criteria:

1. A single specimen which is repeatedly reactive using any food and drug administration "FDA" licensed enzyme immunoassay "EIA" HIV antibody test and confirmed positive using an FDA licensed HIV antibody confirmatory test.

2. A single specimen which is repeatedly reactive using any FDA licensed HIV antigen test and an FDA licensed EIA HIV antibody test. A specimen which is repeatedly reactive to an FDA licensed HIV antigen test shall be confirmed through a neutralization assay. A specimen which is repeatedly reactive to an FDA licensed EIA HIV antibody test shall be tested with an FDA licensed HIV antibody confirmatory test.

3. A single specimen which is tested for the presence of HIV using a molecular amplification method for the detection of HIV nucleic acids consistent with national committee for clinical laboratory standards.

4. A single specimen which is tested for the presence of HIV using viral culture methods.

(f) A test under par. (e) shall be performed by a laboratory which meets the requirements of the federal health care financing administration under the clinical laboratory improvement amendments act of 1988.

(g) 1. An insurer that uses an application asking whether the person to be insured has been tested for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV may ask only whether the person has been tested using one or more of the tests specified in par. (e).

2. Notwithstanding subd. 1., the insurer may not require or request the disclosure of any information as to whether the person to be insured has been tested at an anonymous counseling and testing site designated by the state epidemiologist or at a similar facility in another jurisdiction or through the use of an anonymous home test kit, or to reveal the results of such a test.

(5) POSITIVE TEST RESULT; INSURER'S OBLIGATION. (a) If a test under sub. (4) (e) is positive and, in the normal course of underwriting, affects the issuance or terms of the policy, the insurer shall provide written notice to the person who signed the consent form that the person tested does not meet the insurer's usual underwriting criteria because of a test result. The insurer shall request that the person provide informed consent for disclosure of the test result to a health care provider with whom the person wants to discuss the test result.

(b) If informed consent for disclosure is obtained, the insurer shall provide the designated health care provider with the test result. If the person refuses to give informed consent for disclosure, the insurer shall, upon the person's request, provide the person who signed the consent form with the test result. The insurer shall include with the report of the test result all of the following:

1. A statement that the person should contact a private health care provider, a public health clinic, an AIDS service organization or the Wisconsin AIDSline for additional medical evaluation or referral for such services.

2. The toll−free telephone number of the Wisconsin AIDSline.

3. A copy of the document specified in sub. (4) (d).

(6) CONFIDENTIALITY OF TEST RESULTS. An insurer that requires a person to be tested under sub. (4) (a) may disclose the test result only as described in the consent form obtained under sub. (4) (b) or with written consent for disclosure signed by the person tested or a person specified in sub. (4) (b) 1. to 3.

(7) GROUP POLICIES; ADDITIONAL PROHIBITION. In underwriting group life, accident or health insurance on an individual basis, in addition to the restrictions specified in s. 631.90 (2), Stats., an

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insurer may not use or obtain from any source, including the medical information bureau, inc., any of the following:

(a) The results of a person's test for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV.

(b) Any other information on whether the person has been tested for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV.

History: Cr. Register, May, 1987, No. 377, eff. 6−1−87; r. and recr. Register, April, 1991, No. 424, eff. 5−1−91; am. (1), (3) (b) and (5) (b) 1., r. (3) (c), (d) and (4) (f), renum. (3) (e) to (i) and (4) (g) and (h) to be (3) (c) to (g) and (4) (f) and (g) and am. (3) (f) and (g), (4) (f) and (g), r. and recr. (4) (e), Register, May, 1998, No. 509, eff. 6−1−98; correction in (4) (b) 2. made under s. 13.92 (4) (b) 7., Stats., Register October 2008 No. 634.

Removed by Register December 2010 No. 660. For current adm. code see: http://docs.legis.wisconsin.gov/code/admin_code.

Ins 3.53 APPENDIX A

[Insurer name and address]

WISCONSIN NOTICE AND CONSENT FOR HUMAN IMMUNODEFICIENCY TESTING

REQUEST FOR CONSENT FOR TESTING

To evaluate your insurability, (____insurer name_____) (Insurer) requests that you be tested to determine the presence of human immunodeficiency virus (HIV) antibody or antigens. By signing and dating this form, you agree that this test may be done and that underwriting decisions may be based on the test results. A licensed laboratory will perform one or more tests approved by the Wisconsin Commissioner of Insurance.

PRETESTING CONSIDERATION

Many public health organizations recommend that, if you have any reason to believe you may have been exposed to HIV, you become informed about the implications of the test before being tested. You may obtain information about HIV and counseling from a private health care provider, a public health clinic, or one of the AIDS service organizations on the attached list. You may also wish to obtain an HIV test from an anonymous counseling and testing site before signing this consent form. The Insurer is prohibited from asking you whether you have been tested at an anonymous counseling and testing site and from obtaining the results of such a test. **For further information on these options, contact the Wisconsin AIDSline at 1−800−334−2437.**

MEANING OF POSITIVE TEST RESULTS

This is not a test for AIDS. It is a test for HIV and shows whether you have been infected by the virus. A positive test result may have an effect on your ability to obtain insurance. A positive test result does not mean that you have AIDS, but it does mean that you are at a seriously increased risk of developing problems with your immune system. HIV tests are very sensitive and specific. Errors are rare but they can occur. If your test result is positive, you may wish to consider further independent testing from your physician, a public health clinic, or an anonymous counseling and testing site. **HIV testing may be arranged by calling the Wisconsin AIDSline at 1−800−334−2437.**

NOTIFICATION OF TEST RESULTS

If your HIV test result is negative, no routine notification will be sent to you. If your HIV test result is other than normal, the Insurer will contact you and ask for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the test results.

DISCLOSURE OF TEST RESULTS

All test results will be treated confidentially. The laboratory that does the testing will report the result to the Insurer. If necessary to process your application, the Insurer may disclose your test result to another entity such as a contractor, affiliate, or reinsurer. If your HIV test is positive, the Insurer may report it to the Medical Information Bureau (MIB, Inc.), as described in the notice given to you at the time of application. If your HIV test is negative, no report about it will be made to the MIB, Inc. The organizations described in this paragraph may maintain the test results in a file or data bank. These organizations may not disclose the fact that the test has been done or the result of the test except as permitted by law or authorized in writing by you.

CONSENT

I have read and I understand this notice and consent for HIV testing. I voluntarily consent to this testing and the disclosure of the test result as described above. A photocopy or facsimile of this form will be as valid as the original.

_____/_____

Signature of Proposed Insured or Parent,
Guardian, or Health Care Agent/Date

_____

Name of Proposed Insured (Print)

_____

Date of Birth

_____

Address

_____

City, State, and Zip Code

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Ins 3.54 Home health care benefits under disability insurance policies. (1) PURPOSE. This section implements and interprets ss. 628.34 (1) and (12), 631.20 and 632.895 (1) and (2), Stats., for the purpose of facilitating the administration of claims for coverage of home health care under disability insurance policies and the review of policy forms. The commissioner of insurance shall disapprove a policy under s. 631.20, Stats., if that policy does not meet the minimum requirements specified in this section.

(2) SCOPE. This section applies to disability insurance policies.

(3) DEFINITIONS. In this section:

(a) "Disability insurance policy" means a disability insurance policy as defined under s. 632.895 (1) (a), Stats., which provides coverage of expenses incurred for in−patient hospital care.

(b) "Home health aide services" means nonmedical services performed by a home health aide which:

1. Are not required to be performed by a registered nurse or licensed practical nurse; and

2. Primarily aid the patient in performing normal activities of daily living.

(c) "Home care visits" means the period of a visit to provide home care, without limit on the duration of the visit, except each consecutive 4 hours in a 24−hour period of home health aide services is one visit.

(d) "Medically necessary" means that the service or supply is:

1. Required to diagnose or treat an injury or sickness and shall be performed or prescribed by the physician;

2. Consistent with the diagnosis and treatment of the sickness or injury;

3. In accordance with generally accepted standards of medical practice; and

4. Not solely for the convenience of the insured or the physician.

(4) MINIMUM REQUIREMENTS. (a) All disability insurance policies including, but not limited to, medicare supplement or replacement policies, shall provide a minimum of 40 home care visits in a consecutive 12−month period for each person covered under the policy and shall make available coverage for supplemental home care visits as required by s. 632.895 (2) (e), Stats.

(b) An insurer shall review each home care claim under a disability insurance policy and may not deny coverage of a home care claim based solely on Medicare's denial of benefits.

(c) An insurer may deny coverage of all or a portion of a home health aide service visit because the visit is not medically necessary, not appropriately included in the home care plan or not necessary to prevent or postpone confinement in a hospital or skilled nursing facility only if:

1. The insurer has a reasonable, and documented factual basis for the determination; and

2. The basis for the determination is communicated to the insured in writing.

(d) In determining whether a home care claim, including a claim for home health aide services, is reimbursable under a disability insurance policy, an insurer may apply claim review criteria to determine that home is an appropriate treatment setting for the patient and that it is not reasonable to expect the patient to obtain medically necessary services or supplies on an outpatient basis, subject to the requirements of s. 632.895 (2) (g), Stats.

(e) An insurer shall disclose and clearly define the home care benefits and limitations in a disability insurance policy, certificate and outline of coverage. An insurer may not use the terms "homebound"or "custodial" in the sections of a policy describing home care benefits, exclusions, limitations, or reductions.

(f) In determining whether a home care claim under a disability insurance policy involves medically necessary part−time or intermittent care, an insurer shall give due consideration to the circumstances of each claimant and may not make arbitrary decisions concerning the number of home care visits within a given period which the insurer will reimburse. An insurer may not deny a claim for home care visits without properly reviewing and giving due consideration to the plan of care established by the attending physician under s. 632.895 (1) (b), Stats. An insurer may use claim review criteria based on the number of home care visits in a period for the purpose of determining whether a more thorough review of a home care claim or plan is conducted.

(g) An insurer may use claim review criteria under par. (d) or (f) only if the criteria and review process do not violate s. Ins 6.11. An insurer shall comply with s. 628.34 (1), Stats., when communicating claim review criteria to applicants, insureds, providers or the public.

History: Cr. Register, April, 1976, No. 376, eff. 6−1−87.

Ins 3.55 Benefit appeals under long−term care policies, life insurance−long−term care coverage and Medicare replacement or supplement policies. (1) PURPOSE. This section implements and interprets s. 632.84, Stats., for the purpose of establishing minimum requirements for the internal procedure for benefit appeals that insurers shall provide in long−term care policies, life insurance−long−term care coverage and Medicare replacement or supplement policies. This section also facilitates the review by the commissioner of these policy forms.

(2) SCOPE. This section applies to individual and group nursing home insurance policies and Medicare replacement or supplement policies issued or renewed on or after August 1, 1988, and to long−term care policies and life insurance−long−term care coverage issued or renewed on and after June 1, 1991, except for policies or coverage exempt under s. Ins 3.455 (2) (b). This section does not apply to a health maintenance organization, limited service health organization or preferred provider plan, as those are defined in s. 609.01, Stats.

(3) DEFINITIONS. In this section:

(a) "Benefit appeal" means a request for further consideration of actions involving the denial of a benefit.

(b) "Denial of a benefit" means any denial of a claim, the application of a limitation or exclusion provision, and any refusal to continue coverage.

(c) "Internal procedure" means the insurer's written procedure for handling benefit appeals.

(cg) "Life insurance−long−term care coverage" has the meaning provided under s. Ins 3.46 (3) (j).

(cm) "Long−term care policy" has the meaning provided under s. Ins 3.46 (3) (k).

(d) "Medicare replacement policy" has the meaning given in s. 600.03 (28p), Stats.

(e) "Medicare supplement policy" has the meaning given in s. 600.03 (28r), Stats.

(4) MINIMUM REQUIREMENTS. (a) Pursuant to s. 632.84 (2), Stats., an insurer shall include in any long−term care policy, life insurance−long−term care coverage and any Medicare replacement or supplement policy an internal procedure for benefit appeals.

(b) The insurer shall provide the policyholder and insured with a written description of the benefit appeals internal procedure at the time the insurer gives notice of the denial of a benefit. The written description shall include the name, address, and phone number of the individual designated by the insurer to be responsible for administering the benefit appeals internal procedure.

(c) An insurer shall describe the benefit appeals internal procedure in every policy, group certificate, and outline of coverage. The description shall include a statement on the following:

1. The insured's right to submit a written request in any form, including supporting material, for review by the insurer of the denial of a benefit under the policy; and

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2. The insured's right to receive notification of the disposition of the review within 30 days of the insurer's receipt of the benefit appeal.

(d) An insurer shall retain records pertaining to a benefit appeal filed and the disposition of this appeal for at least 3 years from the date that the insurer files with the commissioner under sub. (5) the annual report in which information concerning the appeal is reported.

(e) No insurer may impose a time limit for filing a benefit appeal that is less than 3 years from the date the insurer gives notice of the denial of a benefit.

(f) An insurer shall make any internal procedure established pursuant to s. 632.84, Stats., available to the commissioner upon request and in as much detail as the commissioner requests.

(5) REPORTS TO THE COMMISSIONER. An insurer shall report to the commissioner by March 31 of each year a summary of all benefit appeals filed during the previous calendar year and the disposition of these appeals, including:

(a) The name of the individual designated by the insurer to be responsible for administering the benefit appeals internal procedure;

(b) Changes made in the administration of claims as a result of the review of benefit appeals;

(c) For each benefit appeal, the line of coverage;

(d) The date each benefit appeal was filed and, if within the calendar year, subsequently resolved;

(e) The date each benefit appeal carried over from the previous calendar year was resolved;

(f) The nature of each benefit appeal; and

(g) A summary of each benefit appeal resolution.

(6) POLICY DISAPPROVAL. The commissioner shall disapprove a policy under s. 631.20, Stats., if that policy does not meet the minimum requirements specified in this section.

History: Cr. Register, May, 1989, No. 401, eff. 1−1−90; am. (1), (2) and (4) (a), r. (3) (f), cr. (3) (cg) and (cm), Register, April, 1991, No. 424, eff. 6−1−91; EmR0817: emerg. am. (3) (cg) and (cm), eff. 6−3−08; CR 08−032: am. (3) (cg) and (cm) Register October 2008 No. 634, eff. 11−1−08.

Note: CR 08−032 first applies to policies or certificates issued on or after January 1, 2009 or on the first renewal date on or after January 1, 2009, but no later than January 1, 2010 for collectively bargained policies or certificates.

Ins 3.60 Disclosure of information on health care claim settlements. (1) PURPOSE. This section implements and interprets s. 628.34 (1) (a) and (12), Stats., for the purpose of allowing insureds and providers access to information on the methodology health insurers use to determine the eligible amount of a health insurance claim and permitting insureds to obtain estimates of amounts that their insurers will pay for specific health care procedures and services.

(2) DEFINITIONS. In this section:

(a) "C.D.T." means the American dental association's current dental terminology.

(b) "C.P.T." means the American medical association's current procedural terminology.

(c) "Provider" means a licensed health care professional.

(3) APPLICABILITY. (a) This section applies to an individual or group health insurance contract or certificate of individual coverage issued in this state that provides for settlement of claims based on a specific methodology, including but not limited to, usual, customary and reasonable charges or prevailing rate in the community, by which the insurer determines the eligible amount of a provider's charge.

(b) This section applies to a health maintenance organization to the extent that it makes claim settlement determinations for out−of−plan services as described in par. (a).

(4) DATA REQUIREMENTS. Any insurer that issues a policy or certificate subject to this section shall base its specific methodology on a data base that meets all of the following conditions:

(a) The fees in the data base shall accurately reflect the amounts charged by providers for health care procedures and services rather than amounts paid to or collected by providers, and may not include any medicare charges or discounted charges from preferred provider organization providers.

(b) The data base shall be capable of all of the following:

1. Compiling and sorting information for providers by C.D.T. code, C.P.T. code or other similar coding acceptable to the commissioner of insurance.

2. Compiling and sorting by zip code or other regional basis, so that charges may be based on the smallest geographic area that will generate a statistically credible claims distribution.

(c) The data base shall be updated at least every 6 months.

(d) No data in the data base at the time of an update under par. (c) may be older than 18 months.

(e) If the insurer uses an outside vendor's data base the insurer may supplement it with data from the insurer's own claim experience.

(f) An insurer may supplement a statistical data base with other information that establishes that providers accept as payment without balance billing amounts less than their initial or represented charge only if:

1. The insurer makes the disclosure required under sub. (6) (a) 1. e.;

2. The information establishes that the provider generally and as a practice accepts the payment without balance billing regardless of which insurer is providing coverage; and

3. The information is no older than 18 months before the date of an update under par. (c), clearly establishes the practice, is documented and is maintained in the insurer's records during the period that the information is used and for 2 years after that date.

(5) DISCLOSURE REQUIREMENTS UPON ISSUANCE OF POLICY. (a) Each policy and certificate subject to this section shall include all of the following:

1. A clear statement, printed prominently on the first page of the policy or in the form of a sticker, letter or other form included with the policy, that the insurer settles claims based on a specific methodology and that the eligible amount of a claim, as determined by the specific methodology, may be less than the provider's billed charge. This subdivision does not apply to a closed panel health maintenance organization that does not provide coverage for nonemergency services by noncontracted providers.

2. If the policy or certificate includes a provision offering to defend the insured if a provider attempts to collect any amount in excess of that determined by the insurer's specific methodology, less coinsurance and deductibles, a clear statement that such a provision does not apply if the insured signs a separate agreement with the provider to pay any balance due.

(b) At the time a policy or certificate is issued, the insurer shall provide the policyholder or certificate holder with the telephone number of a contact person or section of the company that can furnish insureds with the information required to be disclosed under sub. (6).

(6) REQUESTS FOR DISCLOSURE. (a) Each insurer issuing a policy or certificate subject to this section shall, upon request, provide the insured with any of the following:

1. A description of the insurer's specific methodology including, but not limited to, the following:

a. The source of the data used, such as the insurer's claim experience, trade association's data, an expert panel of providers or other source.

b. How frequently the data base is updated.

c. The geographic area used in determining the eligible amount.

d. If applicable, the percentile used to determine usual, customary and reasonable charges.

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e. The conditions and procedures under which a statistical data base is supplemented under sub. (4) (f).

2. The amount allowable under the insurer's guidelines for determination of the eligible amount of a provider's charge for a specific health care procedure or service in a given geographic area. The insurer is required to disclose the specific amount which is an allowable charge under the insurer's guidelines only if the provider's charge exceeds the allowable charge under the guidelines. The estimate may be in the form of a range of payment or maximum payment.

(b) Paragraph (a) does not require an insurer to disclose specifically enumerated proprietary information prohibited from disclosure by a contract between the insurer and the source of the data in the data base.

(c) A request under par. (a) may be oral or written. The insurer may require the insured to provide reasonably specific details, including the provider's estimated charge, and the C.P.T. or C.D.T. code, about the health care procedure or service before responding to the request. The response may be oral or written and the insurer shall respond within 5 working days after the date it receives a sufficient request. As part of the response, the insurer shall inform the requester of all of the following:

1. That the policy benefits are available only to individuals who are eligible for benefits at the time a health care procedure or service is provided.

2. That policy provisions including, but not limited to, preexisting condition and contestable clauses and medical necessity requirements, may cause the insurer to deny a claim.

3. That policy limitations including, but not limited to copayments and deductibles, may reduce the amount the insurer will pay for a health care procedure or service.

4. That a policy may contain exclusions from coverage for specified health care procedures or services.

(d) An insurer that provides a good faith estimate under par. (a) 2., based on the information provided at the time the estimate is requested, is not bound by the estimate.

(e) Upon request, an insurer shall provide the commissioner of insurance with information concerning the insurer's specific methodology.

(7) DISCLOSURE ACCOMPANYING PAYMENT. If an insurer, based on its specific methodology, determines that the eligible amount of a claim is less than the amount billed, the insurer shall disclose with the remittance advice or explanation of benefits form under s. Ins 3.651, which accompanies payment to the provider or the insured, the telephone number of a contact person or section of the company from whom the provider or the insured may request the information specified under sub. (6) (a) 1.

(8) VIOLATION. A pattern of providing inaccurate or misleading responses under sub. (6) (c) is a violation of s. 628.34 (1) (a), Stats.

History: Cr. Register, December, 1992, No. 444, eff. 1−1−93; reprinted to correct copy in (4) (d), (6) (a) 2. and (c) (intro.), Register, February, 1993, No. 446; r. and recr. (7), Register, August, 1993, No. 452, eff. 9−1−93.

Ins 3.65 Standardized claim format. (1) PURPOSE; APPLICABILITY. This section implements s. 632.725 (2) (a) and (b), Stats., by designating and establishing requirements for use of the forms that health care providers in this state shall use on and after July 1, 1993, for providing a health insurance claim form directly to a patient or filing a claim with an insurer on behalf of a patient.

(2) DEFINITIONS. In this section and in s. Ins 3.651:

(a) "ADA dental claim form"means the uniform dental claim form approved by the American dental association for use by dentists.

(b) "CDT−1 codes"means the current dental terminology published by the American dental association.

(c) "CPT−4 codes"means the current procedural terminology published by the American medical association.

(d) "DSM−III−R codes"means the American psychiatric association's codes for mental disorders.

(e) "HCFA"means the federal health care financing administration of the U.S. department of health and human services.

(f) "HCFA−1450 form"means the health insurance claim form published by HCFA for use by institutional providers.

(g) "HCFA−1500 form"means the health insurance claim form published by HCFA for use by health care professionals.

(h) "HCPCS codes"means HCFA's common procedure coding system which includes all of the following:

1. Level 1 codes which are the CPT−4 codes.

2. Level 2 codes which are codes for procedures for which there are no CPT−4 codes.

3. Levels 1 and 2 modifiers.

(i) "Health care provider"has the meaning given in s. 632.725 (1), Stats.

(j) "ICD−9−CM codes"means the disease codes in the international classification of diseases, 9th revision, clinical modification published by the U.S. department of health and human services.

(k) "Medicare"means Title XVIII of the federal social security act.

(L) "Medical assistance"means Title XIX of the federal social security act.

(m) "Revenue codes"means the codes which are included in the Wisconsin uniform billing manual and which are established for use by institutional health care providers by the national uniform billing committee.

Note: The publications and forms referred to in subsection (2) may be obtained as follows:HCFA−1500 form and instructions

From the U.S. Government Printing Office, 710 North Capitol Street NW, Washington, DC 20401, all of the following:

HCPCS codes

ICD−9−CM codes

HCFA−1450 form and instructions

From the American Dental Association, 211 East Chicago Avenue, Chicago, IL 60611, both of the following:

CDT−1 codes

ADA dental claim form and CDT−1 User's Manual

From Order Department: OP054192, the American Medical Association, P. O. Box 10950, Chicago, IL 60610: CPT−4 codes

From the American Psychiatric Association, 1400 K Street, NW, Washington, DC 20005: DSM−III−R codes

From the Wisconsin Hospital Association, 5721 Odana Road, Madison, WI 53719: Wisconsin Uniform Billing Manual and revenue codes

(3) USE OF HCFA−1500 FORM. (a) *Required users; instructions.* For providing a health insurance claim form directly to a patient or filing a claim with an insurer on behalf of a patient, all of the following health care providers shall use the format of the HCFA−1500 form, following HCFA's instructions for use:

1. A nurse licensed under ch. 441, Stats.

2. A chiropractor licensed under ch. 446, Stats.

3. A physician, podiatrist or physical therapist licensed under ch. 448, Stats.

4. An occupational therapist, occupational therapy assistant or respiratory care practitioner certified under ch. 448, Stats.

5. An optometrist licensed under ch. 449, Stats.

6. An acupuncturist licensed under ch. 451, Stats.

7. A psychologist licensed under ch. 455, Stats.

8. A speech−language pathologist or audiologist licensed under subch. II of ch. 459, Stats., or a speech and language pathologist licensed by the department of public instruction.

9. A social worker, marriage and family therapist or professional counselor certified under ch. 457, Stats.

10. A partnership of any providers specified under subds. 1. to 9.

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11. A corporation of any providers specified under subds. 1. to 9. that provides health care services.

12. An operational cooperative sickness care plan organized under ss. 185.981 to 185.985, Stats., that directly provides services through salaried employees in its own facility.

(b) *Coding requirements.* In addition to HCFA's coding instructions, the following restrictions and conditions apply to the use of the HCFA−1500 form:

1. The only coding systems an insurer may require a health care provider to use are the following:

a. HCPCS codes.

b. ICD−9−CM codes.

c. DSM−III−R codes, if no ICD−9−CM code is available.

2. For anesthesia services for which there is no applicable HCPCS level 1 anesthesia code, a health care provider shall use the applicable HCPCS level 1 surgery code.

3. An insurer may not require a health care provider to use any other verbal descriptor with a code or to furnish additional information with the initial submission of a HCFA−1500 form except under the following circumstances:

a. When the procedure code used describes a treatment or service which is not otherwise classified.

b. When the procedure code is followed by the CPT−4 modifier 22, 52 or 99. A health care provider using the modifier 99 may use item 19 of the HCFA−1500 form to explain the multiple modifiers.

c. When required by a contract between the insurer and health care provider.

4. A health care provider may use item 19 of the HCFA−1500 form to indicate that the form is an amended version of a form previously submitted to the same insurer by inserting the word "amended" in the space provided.

(c) *Use of unique identifiers.* In completing the HCFA−1500 form, the individual or entity filing the claim shall do all of the following:

1. In item 17a, use the unique physician identifier number assigned by HCFA or, if the physician does not have such a number, the physician's taxpayer identification number assigned by the U. S. internal revenue service.

2. In item 33, use both of the following:

a. The name and address of the payee.

b. The unique physician identifier number assigned by HCFA to the individual health care provider who performed the procedure or ordered the service or, if the individual does not have such a number, the individual's taxpayer identification number assigned by the U. S. internal revenue service.

(4) USE OF HCFA−1450 FORM. (a) *Required users; instructions.* For providing a health insurance claim form directly to a patient or filing a claim on behalf of a patient, all of the following health care providers shall use the format of the HCFA−1450 form, following the instructions for use in the Wisconsin uniform billing manual:

1. A hospice licensed under subch. IV of ch. 50, Stats.

2. An inpatient health care facility, as defined in s. 50.135 (1), Stats.

3. A community−based residential facility, as defined in s. 50.01 (1g), Stats.

(b) *Coding requirements.* The only coding systems an insurer may require a health care provider to use are the following:

1. ICD−9−CM codes.

2. Revenue codes.

3. If charges for professional health care provider services are included, HCPCS or DSM−III−R codes.

(c) *Claims for outpatient services; supplemental form permitted.* A hospital may use a HCFA−1500 form to supplement a HCFA−1450 form if necessary to complete a claim for outpatient services.

(5) USE OF ADA DENTAL CLAIM FORM. (a) *Required users; instructions.* For providing a health insurance claim form directly to a patient or filing a claim with an insurer on behalf of a patient, a dentist or a corporation or partnership of dentists shall use the format of the ADA dental claim form, following the instructions for use in the American dental association CDT−1 user's manual.

(b) *Coding.* An insurer may not require a dentist to use any code other than the following:

1. CDT−1 codes.

2. CPT−4 codes.

(6) GENERAL PROVISIONS. (a) *Insurers to accept forms.* No insurer may refuse to accept a form specified in sub. (3) (a), (4) (a) or (5) (a) as proof of a claim.

(b) *Filing claims.* A health care provider may file a claim with an insurer using either a paper form or electronic transmission. If a health care provider does not file a claim on behalf of a patient, the health care provider shall provide the patient with the same form that would have been used if the provider had filed a claim on behalf of the patient.

(c) *Insurers may require additional information.* 1. If the information conveyed by standard coding is insufficient to enable an insurer to determine eligibility for payment, the insurer may require a health care provider to furnish additional medical records to determine medical necessity or the nature of the procedure or service provided.

2. The 30−day period allowed for payment of a claim under s. 628.46 (1), Stats., begins when the insurer has sufficient information to determine eligibility for payment.

(d) *Use of current forms and codes.* In complying with this section, a health care provider shall do all of the following that are applicable:

1. Use the most current version of the HCFA−1500 or HCFA−1450 claim form and accompanying instructions by the mandatory effective date HCFA specifies for use in filing medicare claims.

2. Begin using modifications to a required coding system for all billing and claim forms by the mandatory effective date HCFA specifies for use in filing medicare claims.

3. Use the most current version of the ADA dental claim form.

History: Cr. Register, August, 1993, No. 452, eff. 9−1−93; am. (6) (b), Register, February, 1994, No. 458, eff. 3−1−94; corrections in (4) (a) 2. and 3. made under s. 13.93 (2m) (b) 7., Stats., Register, July, 1999, No. 523.

Ins 3.651 Standardized explanation of benefits and remittance advice format. (1) PURPOSE. This section implements s. 632.725 (2) (c), Stats., by prescribing the requirements for the following, to be used by insurers providing health care coverage to one or more residents of this state:

(a) Remittance advice forms that insurers furnish to health care providers.

(b) Explanation of benefits forms that insurers furnish to insureds.

(2) DEFINITIONS. In addition to the definitions in s. Ins 3.65, in this section, "claim adjustment reason codes"means the claim disposition codes of the American national standards institute accredited standards committee X12 (ASC X12).

Note: The claim adjustment reason codes referenced in subsections (2), (3) (b) 4. i., (4) (a) 5. f. and (5), form OCI 17−007, may be obtained from the Office of the Commissioner of Insurance, P. O. Box 7873, 121 East Wilson Street, Madison, Wisconsin 53707−7873.

(3) REMITTANCE ADVICE TO HEALTH CARE PROVIDERS. (a) *Use of remittance advice form required; exception.* 1. With each payment to a health care provider, an insurer shall provide a remittance advice form conforming to the format specified in Appendix A, except as provided in subd. 2. and par. (d).

2. The remittance advice form of an insurer with less than $50,000 in annual premiums for health insurance sold in this state,

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as reported in its most recent annual statement, is not required to conform to the format specified in Appendix A but, with each payment to a health care provider, the insurer shall provide a remittance advice form which includes all of the applicable information specified in par. (b).

(b) *Information required.* The remittance advice form shall include, at a minimum, all of the following information:

1. The insurer's name and address and the telephone number of a section of the insurer designated to handle questions and appeals from health care providers.

2. The insured's name and policy number, certificate number or both.

3. The last name followed by the first name and middle initial of each patient for whom the claim is being paid, the patient identification number and the patient account number, if it has been supplied by the health care provider.

4. For each claim, all of the following on a single line:

a. The date or dates the service was provided or procedure performed.

b. The CPT−4, HCPCS or CDT−1 code.

c. The amount charged by the health care provider.

d. The amount allowed by the insurer.

e. The deductible amount.

f. The copayment amount.

g. The coinsurance amount.

h. The amount of the contractual discount.

i. Each claim adjustment reason code, unless the claim is adjusted solely because of a deductible, copayment or coinsurance or a combination of any of them.

j. The amount paid by the insurer toward the charge.

(c) *Grouping of claims required.* 1. If an insurer includes claims for more than one policyholder or certificate holder on the same remittance advice form, all claims for the same policyholder or certificate holder shall be grouped together.

2. If an insurer includes claims for more than one patient on the same remittance advice form, all claims for the same patient shall be grouped together.

(d) *Format; exceptions.* Notwithstanding par. (a) 1. and Appendix A:

1. An insurer may print its remittance advice form in either horizontal or vertical format.

2. A remittance advice form need not include a column for any item specified in par. (b) 4. which is not applicable, but the order of the columns that are included may not vary from the order shown in Appendix A, except as provided in subd. 3.

3. A remittance advice form may provide additional information about claims by including one or more columns not shown in Appendix A immediately before the column designated for the claim adjustment reason code.

4. An insurer may alter the wording of a column heading shown in Appendix A provided the meaning remains the same.

5. If necessary for clarity when claims for more than one insured or more than one patient are included on the same form, an insurer shall vary the location of the information specified in par. (b) 2. and 3. to ensure that it appears with the claim information to which it applies.

(e) An insurer shall send the remittance advice form to the payee designated on the claim form.

Note: If, on March 1, 1994, an insurer has a contract with a health care provider that governs the form and content of remittance advice forms, s. Ins 3.651 (3), as affected March 1, 1994, first applies to the insurer on the date the contract is renewed, but no later than December 31, 1994.

(4) EXPLANATION OF BENEFITS FOR INSUREDS. (a) The explanation of benefits form for insureds shall include, at a minimum, all of the following:

1. The insurer's name and address and the telephone number of the section of the insurer designated to handle questions and appeals from insureds relating to payments.

2. The insured's name, address and policy number, certificate number or both.

3. A statement as to whether payment accompanies the form, payment has been made to the health care provider or payment has been denied.

4. The last name followed by the first name and middle initial of each patient insured under the policy or certificate for whom claim information is being reported, and the patient account number, if it has been supplied by the health care provider.

5. For each patient listed, all of the following that are applicable, using a single line for each procedure or service:

a. The health care provider as indicated on the claim form.

b. The date the service was provided or procedure performed.

c. The CPT−4, HCPCS or CDT−1 code.

d. The amount charged by the health care provider if the insured may be liable for any of the difference between the amount charged and the amount allowed by the insurer.

e. The amount allowed by the insurer. An insurer may modify this requirement if necessary to provide information relating to supplemental insurance.

f. Each claim adjustment reason code, unless the claim is for a dental procedure for which there is no applicable code, in which case the insurer shall provide an appropriate narrative explanation as a replacement for the information required under subd. 7.

g. The applicable deductible amount, if any.

h. The applicable copayment amount, if any.

i. The amount paid by the insurer toward the charge.

6. A general description of each procedure performed or service provided.

7. A narrative explanation of each claim adjustment reason code. An insurer may provide information in addition to the narrative accompanying the code on form OCI 17−007.

8. Any of the following that apply:

a. The total deductible amount remaining for the policy period.

b. The total out−of−pocket amount remaining for the policy period.

c. The remaining amount of the policy's lifetime limit.

d. The annual benefit limit.

(b) Unless requested by the insured, an insurer is not required to provide an explanation of benefits if the insured has no liability for payment for any procedure or service, or is liable only for a fixed dollar copayment which is payable at the time the procedure or service is provided.

(5) CLAIM ADJUSTMENT REASON CODES; USE. The office shall prepare updated claim adjustment reason code forms at least semiannually and shall notify insurers of their availability. In preparing remittance advice and explanation of benefits forms, an insurer shall use the claim adjustment reason codes provided by the office of the commissioner of insurance by no later than the first day of the 4th month beginning after being notified that an updated list of codes is available.

History: Cr. Register, August, 1993, No. 452, eff. 9−1−93; emer. r. and recr. (3) and (5), renum. (4) (a) 5. b., c. and 8. to 11. to be (4) (a) 5. c., b. and 8. a. to d., am. (4) (a) 6. and 7., cr. (4) (a) 8. (intro.), eff. 10−1−93; r. and recr. (3) and (5), renum. (4) (a) 5. b., c. and 8. to 11. to be (4) (a) 5. c., b. and 8. a. to d., am. (4) (a) 6. and 7., cr. (4) (a) 8. (intro.), Register, February, 1994, No. 458, eff. 3−1−94.

Ins 3.67 Benefit appeals under certain policies. (1) DEFINITIONS. In this section:

(a) "Defined network plan" has the meaning provided under s. 609.01 (1b), Stats.

(am) "Expedited request" means a request where the standard resolution process may include any of the following:

Removed by Register December 2010 No. 660. For current adm. code see: http://docs.legis.wisconsin.gov/code/admin_code.

1. Serious jeopardy to the life or health of the enrollee or the ability of the enrollee to regain maximum function.

2. In the opinion of a physician with knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

3. Is determined to be an expedited request by a physician with knowledge of the enrollee's medical condition.

(b) "Grievance" means any dissatisfaction with the provision of services or claims practices of an insurer offering a defined network plan, limited service health organization or preferred provider plan or administration of a defined network plan, limited service health organization or preferred provider plan by the insurer that is expressed in writing to the insurer by, or on behalf of, an enrollee.

(c) "Health care plan" has the meaning provided under s. 628.36 (2) (a) 1., Stats., including fixed indemnity and specified disease insurance but does not include coverage ancillary to property and casualty insurance and Medicare + Choice plans.

(d) "Limited service health organization" has the meaning provided under s. 609.01 (3), Stats.

(f) "Self−insured plan" has the meaning provided under s. 632.85 (1) (c), Stats.

(2) DRUGS AND DEVICES. A health care plan or self−insured plan that provides coverage of only certain specified prescription drugs or devices shall develop a process through which an enrollee's physician may present medical evidence to obtain an individual patient exception for coverage of a prescription drug or device.

(3) COVERAGE OF EXPERIMENTAL TREATMENTS. (a) Any coverage limitations for experimental treatment shall be defined and clearly disclosed in every policy issued by a health care plan or self−insured plan in accordance with s. 632.855 (2), Stats.

(b) A health care plan or self−insured plan that limits coverage for experimental treatment shall have an internal procedure consistent with s. 632.855 (3), Stats., including issuing a written coverage decision within 5 business days of receipt of the request.

(4) APPEAL PROCEDURE. The procedure for defined network plan enrollees to appeal a decision under subs. (2) and (3) is delineated under s. Ins 18.03. For other health care plans, the appeal procedure established under this section shall include all of the following:

(a) The opportunity for the policyholder or certificate holder, or an authorized representative of the policyholder or certificate holder, to submit a written request, which may be in any form and which may include supporting material, for review by the insurer of the denial of any benefits under the policy.

(b) If an insurer denies any benefit under sub. (2) or (3), the insurer shall, at the time the insurer gives notice of the denial of benefits, provide the policyholder with a written description of the appeal process.

(c) The health care plan or self−insured plan shall acknowledge, in writing, a request for review of coverage under sub. (2), within 5 business days of receiving it.

(d) Within 30 calendar days after receiving the request under sub. (2) or (3), the health care plan or self−insured plan shall provide the disposition of the review and notify the person who submitted the request for review of the results of the review.

(e) A process to resolve an expedited request for review as expeditiously as the health condition requires but not to exceed 72 hours from the receipt of a substantially completed request under sub. (2) or (3).

(f) An insurer shall describe the procedure established under this subsection in every policy, group certificate and outline of coverage issued in connection with a health care plan.

(g) Each insurer offering a health care plan shall keep together, at its home or principal office, all records of appeals under this subsection. The insurer shall make these records available for review during examinations or at the request of the commissioner.

History: Cr. Register, February, 2000, No. 530, eff. 3−1−00; correction in (1) (e) made under s. 13.93 (2m) (b) 7., Stats., Register December 2002 No. 564; correction in (4) made under s. 13.93 (2m) (b) 7., Stats., Register April 2003 No. 568; CR 05−059: renum. (1) (a) and (e) to be (1) (am) and (a), am. (1) (a) and (b) and (4) (intro.) Register February 2006 No. 602, eff. 3−1−06.

Ins 3.70 Methods of aggregating creditable coverage for the Health Insurance Risk Sharing Plan. The method of aggregating creditable coverage for purposes of s. 149.10 (2t) (a), Stats., shall comply with 45 CFR 146.113 (a) (3).

History: Cr. Register, September, 1998, No. 513, eff. 10−1−98.

Removed by Register December 2010 No. 660. For current adm. code see: http://docs.legis.wisconsin.gov/code/admin_code.

APPENDIX A
REMITTANCE ADVICE

INSURER
NAME & ADDRESS
CONTACT #

PAYEE/PROVIDER
NAME & ADDRESS

INSURED NAME & ADDRESS **INSURED ID #**
PATIENT NAME **PATIENT ID #** **PATIENT ACCT #**

SERVICE DATE(S)	SERVICE CODE	CHARGED AMOUNT	ALLOWED AMOUNT	DEDUCT−IBLE	COPAY	COINSUR−ANCE	DISCOUNT	ANSI CODE	PAID

OCI 26−061 (C 09/93)