will be more effective and litigation will be substantially reduced if there is increased uniformity of these clauses. This section does not require the use of coordination of benefit or "other insurance" provisions but if such provisions are used, they must adhere substantially to this section. Liberalization of the prescribed language including rearrangement of the order of the clauses is permitted provided that the modified language is not less favorable to the insured person. Provisions for the reduction in benefits because of other insurance which are inconsistent with this section violate the criteria of s. 631.20, Stats., and may not be used.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) For the purposes of par. (c), the rules establishing the order of benefit determination are:

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

2. The benefits of a Plan which covers the person on whose expenses claim is based as a dependent of a male person shall be determined before the benefits of a Plan which covers the person as a dependent of a female person; except that in case of a person for whom claim is made as a dependent child,

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

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

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

3. When subd. 1. and 2. do not establish an order of benefit determination, the benefits of a Plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered the person the shorter period of time.

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

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

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

paid shall be deemed to be benefits paid under this Plan and, to the extent of the payments, the insurer or service plan shall be fully discharged from liability under this Plan.

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

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

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

(b) The definition may include all group policies or group subscriber contracts as well as such group-type contracts as are not available to the general public and can be obtained and maintained only because of the covered person's membership in or connection with a particular organization or group. Group-type contracts answering this description may be included in the definition, at the option of the insurer and its policyholder-client, whether or not individual policy forms are utilized and whether the group-type coverage is designated as "franchise" or "blanket" or in some other fashion.

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

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

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

(f) If Medicare or similar governmental benefits are included in the definition of a Plan, such benefits may be taken into consideration without expanding the definition of Allowable Expenses beyond the hospital,

medical and surgical benefits as may be provided by the government program.

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

(b) If a claimant's effective date of coverage under a given Plan is subsequent to the date the carrier first contracted to provide the Plan for the group concerned (employer, union, association, etc.), then, in the absence of specific information to the contrary, the carrier shall assume, for purposes of this section, that the claimant's length of time covered under that Plan shall be measured from the claimant's effective date of coverage. If a claimant's effective date of coverage under a given Plan is the same as the date the carrier first contracted to provide the Plan for the group concerned, then the carrier shall request the group concerned to furnish the date the claimant first became covered under the earliest of any prior Plans the group may have had. If such date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time coverage under that Plan has been in force.

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

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

(a) Improving exchange of benefit information;

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

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

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

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

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

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

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

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

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

(20) EFFECTIVE DATE. This section shall become effective on September 1, 1980. The authorized clauses, authorized modifications thereof and the substantive requirements of this section shall apply to all policy and contract forms subject to this section that are issued on or after this effective date. Policies or contracts which are otherwise subject to this section which are in force as of the effective date shall comply with this section by the later of the next anniversary or renewal date of the group policy or contract, or the expiration of the applicable collectively bargained contract pursuant to which they were written, if any.

History: Cr. Register, July, 1980, No. 295, eff. 9-1-80; am. (2), Register, January, 1981, No. 301, eff. 2-1-81.

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

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

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

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

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

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

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

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

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

(a) Hospital room and board daily expense benefits in a maximum dollar amount approximating the average semi-private rate charged in the

major metropolitan area of this state, for a maximum duration of 70 days per calendar year;

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

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

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

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

(b) Payment of benefits at the rate of 80% of covered hospital, medical, and surgical expenses which are in excess of the deductible, until 20% of such expenses in a benefit period reaches $1,000, after which benefits shall be paid at 100% for the remainder of the benefit period; provided, however, benefits for outpatient treatment of mental illness, if covered by the policy, may be limited as provided in par. (g), and surgical expenses shall be covered at a usual, customary and reasonable level.

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

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

(e) Payment for all services covered under the contract by any licensed health care professional qualified to provide the services; except payment for psychologists' services may be conditioned upon referral or supervision by a physician.

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

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

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

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

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

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

History: Cr. Register, April, 1981, No. 304, eff. 5-1-81; am. (2) (b) and (e), cr. (2) (f) and (g), Register, October, 1982, No. 322, eff. 11-1-82.