

Chapter Ins 3

CASUALTY INSURANCE

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

**Ins 3.02 Automobile fleets, vehicles not included in.** Individually owned motor vehicles cannot be included or covered by fleet rates. The deter-

mining factor for inclusion under fleet coverage must be ownership and not management or use.

**Ins 3.04 Dividends not deducted from premiums in computing loss reserves.** Premiums returned to policyholders as dividends may not be deducted from the earned premiums in computing loss reserves under s. 623.04, Stats.

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

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

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

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

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

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

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

1. Any state, territory or possession of the United States of America;
  2. Any political subdivision of any such state, territory or possession;
- or
3. Any agency, authority or corporate or other instrumentality of any one or more of the foregoing, or which are guaranteed by any of the foregoing.

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

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

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

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

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

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

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ary 1, 1984, or the amount required by statute 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 con-

tingency 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 U.S.C.s. 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 employe, agent, or representative of any issuer of municipal bonds or to any employe, 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 employe, 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.

Register, March, 1986, No. 363

**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 7.01 (5) (a).

(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 U.S.C. s. 832 (e) as amended.

(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 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 7.01 (24) (t).

(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.

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(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.



(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 s. Ins 6.73 (4) (f).

(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 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 insurance. 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 subs. (13) or (18).
3. The contingency reserve required by subs. (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 Valua- tion 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 Valua- tion 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.

(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 two 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 in-

dividual 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 employe 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

employe 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 employe or any member of their immediate family has a financial interest; or 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 employe 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) If a member of a holding company system as defined in s. Ins 12.01 (3) (e), 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 affli-



ate 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).

(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.

**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.

**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 insurance contract. Multiple peril Register, November, 1989, No. 407

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), (5), 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.

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(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 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 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 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 par. (jm), 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,

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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 insurer 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), (5), 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 insurer 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 Ins 3.39 (4), (5), and (6).

(jm) Medicare replacement policies as defined in s. 600.03 (28p), 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 disenroll which shall:

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 similar language approved by the commissioner:

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*emergency  
renewal  
1-1-92*

You may disenroll from 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 insurer before disenrolling.

(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”

“Notice! See Reduction 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:

“Notice! See Elimination Endorsement Included Herein”

“Notice! See Exclusion Endorsement Included Herein”

“Notice! See Exception Endorsement Included Herein”

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"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. Register, September, 1986, No. 369



**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 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 employe 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 his profession or occupation on a full-time basis or ceases to be an active member of the association or labor union or an employe 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 employes of such association and employes of member organizations of such association, and

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(c) the individuals supplying raw materials to a single processing plant and the employes 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.

**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 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 (34m) (c), Stats., the following are eligible for blanket accident and health insurance: 1. Volunteer fire departments, 2. National guard units, 3. Newspaper delivery boys, 4. Dependents of students, 5. Volunteer civil defense organizations, 6. Volunteer auxiliary police organizations, 7. Law enforcement agencies, 8. Cooperatives 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, 1986, No. 369

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.

**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.

(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:

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. a. 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.

b. 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:

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

ii. Eight percent.

c. 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;

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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.

## 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.

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 incurrual 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.

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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 CIDD 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.

**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), Stats., [1973] 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.

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**Ins 3.20 Substandard risk automobile physical damage insurance for financed vehicles.** (1) **PURPOSE.** In accordance with s. 204.49 (4), 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 his own insurance, and if he 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.

**Ins 3.23 Franchise accident and sickness insurance.** (1) **FRANCHISE GROUP HEADQUARTERS.** A franchise group described in s. 600.03 (34m) (d), 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.

**Ins 3.25 Credit life 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, 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:

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(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 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

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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 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 the indebtedness must meet the following minimum requirements:

1. In the case of credit life or credit accident and sickness insurance for which premiums are payable other than by a single premium, and in the case of level term credit life insurance, the refund of premium shall be not less than the pro rata unearned gross premium. In the case of credit life or credit accident and sickness insurance paid by a single premium, the refund shall be not less than the amount computed by the "sum of digits" formula commonly known as the "Rule of 78."

2. In the case of credit life or credit accident and sickness insurance for which an amount is charged other than in a single sum, and in the case of level term credit life insurance, the refund of the amount charged to the debtor for insurance shall be equal to the pro rata unearned gross amount charged or to be charged. In the case of credit life and credit accident and sickness insurance for which the whole amount is charged in a single sum the refund shall be not less than the amount computed by the "sum of the digits" formula commonly known as the "Rule of 78."

3. Refunds shall be based on the number of full months prepaid from the maturity date of the policy, counting a fractional month of 16 days or more as a full month.

4. Upon termination of indebtedness repayable in a single sum prior to the 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.

Note: The following par. (g) will be effective on April 1, 1990.

(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 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.

(c) On or before October 1, 1990, and each 3 years after that, 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 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 Appendix B, 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 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. 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;

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. 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. 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 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 two 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. 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 65 or over at the time indebtedness is incurred or debtors who will have attained 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. 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.

(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 subs. 1. and 2. below:

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 3 months following the effective date of coverage. Under open-end credit plans, the effective date of cover-

age 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 age 65 or over at the time the indebtedness is incurred, or debtors who will have attained 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:

Ins 3

<u>Plan of Benefits</u>	<u>Minimum Life Years Exposure</u>
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:

COMMISSIONER OF INSURANCE

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Ins 3

<u>Plan of Benefits</u>	<u>Prima Facie Incidence</u>	<u>Basic Loss Ratio</u>
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:

<u>Line Number</u>	<u>Description of Item</u>	<u>Value</u>
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 in the form of Appendix B. The experience data for each calendar year shall be submitted as specified in the instructions to the annual statement and shall be accompanied by the following:

(a) Written certification by an officer of the insurer that the report fully complies with this reporting requirement and is prepared according to the instructions in sub. (21) except as may be noted and explained in such certification; and

(b) An actuarial description specifying the basis of calculation of unearned premium reserves and claim reserves and liabilities for each category of business, signed by a qualified actuary as defined in s. Ins 6.12.

(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 reserve shall be computed according to the method for calculating unearned premiums prescribed in sub. (21) for use in completing Appendix B.

(21) INSTRUCTIONS FOR COMPLETING APPENDIX B. (a) Data shall be provided for all coverage in force at any time during the calendar year, excluding coverage for which no indentifiable charge is made to insured debtors.

(b) 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:

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

2. For single premium credit accident and sickness coverage with substantially equal monthly benefits and with coterminous 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;

3. 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;

4. 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;

5. 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 pay-

ment, an appropriate combination of methods described in this paragraph; or

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

7. In this paragraph, a "dollar-month of coverage" means one dollar of coverage for one month.

(c) 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.

(d) 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.

(e) Prima facie earned premium shall be reported as the premium that would have been earned if all coverage had been written at the prima facie premium rates in effect as of the last day of the calendar year for which the experience is submitted. Thus, an adjustment to actual premium will be required for all coverage written at other than the prima facie rate and for any business written at a prima facie rate that differs from the corresponding prima facie rate in effect on the last day of the calendar year for which the experience is submitted.

(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.



Appendix A

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

BENEFITS PAYABLE AFTER:

Original number of equal monthly installments	<u>the 14th day of disability</u>		<u>the 30th day of disability</u>	
	<u>Retroactive to first day</u>	<u>Non- retroactive</u>	<u>Retroactive to first day</u>	<u>Non- retroactive</u>
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

## Appendix A — Group Credit Disability Insurance (continued)

BENEFITS PAYABLE AFTER:

<u>Original number of equal monthly installments</u>	<u>the 14th day of disability</u>		<u>the 30th day of disability</u>	
	<u>Retroactive to first day</u>	<u>Non- retroactive</u>	<u>Retroactive to first day</u>	<u>Non- retroactive</u>
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
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

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Appendix A — Group Credit Disability Insurance (continued)

BENEFITS PAYABLE AFTER:

<u>Original number of equal monthly installments</u>	<u>the 14th day of disability</u>		<u>the 30th day of disability</u>	
	<u>Retroactive to first day</u>	<u>Non- retroactive</u>	<u>Retroactive to first day</u>	<u>Non- retroactive</u>
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

## Appendix A — Group Credit Disability Insurance (continued)

BENEFITS PAYABLE AFTER:

<u>Original number of equal monthly installments</u>	<u>the 14th day of disability</u>		<u>the 30th day of disability</u>	
	<u>Retroactive to first day</u>	<u>Non- retroactive</u>	<u>Retroactive to first day</u>	<u>Non- retroactive</u>
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
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  $1.25 \times \text{Claim Cost} + \$60$  (subject to a maximum of  $2 \times \text{Claim Cost}$ )

Appendix B

CREDIT LIFE AND ACCIDENT AND HEALTH EXPERIENCE EXHIBIT

For the year ended December 31, 19.....

Of the ..... Insurance Company  
 Address (City, State and Zip Code) .....  
 MAC Group Code ..... MAC Company Code .....  
 To be filed on or before the date required in the instructions to the annual statement.  
 Direct Business in the State of .....

PART 1—CREDIT LIFE INSURANCE

	Single	Joint	Total
<b>1. Earned Premiums:</b>			
A. Gross written premiums .....			
B. Refunds on terminations .....			
C. Net written premiums (A-B) .....			
D. Premium reserves, start of period .....			
E. Premium reserves, end of period .....			
F. Actual earned premiums (C+D-E) .....			
G. Earned premiums at prima facie rates .....			
<b>2. Incurred Claims:</b>			
A. Claims paid .....			
B. Unreported claim reserve, start of period .....			
C. Unreported claim reserve, end of period .....			
D. Claim reserves, start of period .....			
E. Claim reserves, end of period .....			
F. Incurred claims (A-B+C-D+E) .....			
<b>3. Loss Ratio:</b>			
A. Actual loss ratio (2F/1F) .....	%	%	%
B. Loss ratio at prima facie rates (2F/1G) .....	%	%	%
<b>4. Mean Insurance in Force</b>			
5. Losses per \$1,000 mean insurance in force			
[(1,000x2F)/4]			

PART 2—CREDIT ACCIDENT AND HEALTH INSURANCE

	7 Day Rate	14 Day Rate	14 Day Non-Rate	30 Day Rate	30 Day Non-Rate	Other	Total
<b>1. Earned Premiums:</b>							
A. Gross written premiums .....							
B. Refunds on terminations .....							
C. Net written premiums (A-B) .....							
D. Premium reserves, start of period .....							
E. Premium reserves, end of period .....							
F. Actual earned premium (C+D-E) .....							
G. Earned premiums at prima facie rates .....							
<b>2. Incurred Claims:</b>							
A. Claims paid .....							
B. Unreported claim reserve, start of period .....							
C. Unreported claim reserve, end of period .....							
D. Claim reserves, start of period .....							
E. Claim reserves, end of period .....							
F. Incurred claims (A-B+C-D+E) .....							
<b>3. Loss Ratio:</b>							
A. Actual loss ratio (2F/1F) .....	%	%	%	%	%	%	%
B. Loss ratio at prima facie rates (2F/1G) .....	%	%	%	%	%	%	%

**Ins 3.26 Unfair trade practices in credit life 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 Wisconsin Statutes: 601.04; 601.01 (3) (a), (b), (c), (g) and (h); 601.41 (1), (2) and (3) and ch. 628.

(2) **SCOPE.** This rule shall apply to the transaction of credit life insurance as defined in s. Ins 6.75 (1) (a) 1. and 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) above:

(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 lesser 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 reasonable 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 employe 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.

**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).

(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. 185.991, 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 pro-

moting 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, 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, billboards and similar displays, excluding advertisements prepared for the sole purpose of obtaining employes, 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 employes 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

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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. 185.991, 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 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.

(j) A *testimonial* means any statement made by a policyholder, certificateholder 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.

(1) 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 employes 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 (34m) (a) and (b), 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) (1).

(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) (1).

(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 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 appropriate, 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 workmen's 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

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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 his 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

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.

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(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. Workmen's 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 fireman 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.

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.

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(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, cancelability 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 his 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).

(1) 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 pars. (a), (b), (c), (d) or (e) above. 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, 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.

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

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(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 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)

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.

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(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.

(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.

**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 Stats. interpreted or implemented by this rule include but are not limited to ss. 601.04 (3), 601.01 (3) (b) 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 (35) (d) 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 has not withheld any information or concealed any facts in completing the application; however, the applicant may be required to state that his answers are true and complete to the best of his 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 prepares and shall set down in each such form all material information disclosed to him 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.

(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 disease 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) of this subsection.

(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

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issued after that date and sub. (5) (d) and (e) shall apply to such activities after February 1, 1975.

Note: See sub. (7) for various effective dates for certain subsections.

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.

**Ins 3.29 Replacement of accident and sickness insurance.** (1) **PURPOSE.** The purpose of this rule 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 rule implements and interprets ss. 601.01 (3) (b) 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 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 insurance subject to s. Ins 3.39 (4), (5) and (6),

(b) Accident only,

(c) Single premium nonrenewable,

(d) Nonprofit dental care,

(e) Nonprofit prepaid optometric service,

(f) A limited policy conforming to 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 Register, December, 1984, No. 348

(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) of this subsection.

(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

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 Ins 6.51 (3).

(d) *Direct response insurance* is insurance issued to an applicant who has himself completed the application and forwarded it directly to the insurer in response to a solicitation coming into his 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.

(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) (a) **NOTICE TO APPLICANT.** 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.



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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), (5), and (6), 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.

**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 (34m) (b) (c) and (d), 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.

**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 ss. 185.981 or ch. 613, Stats. Sections of Stats. 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 (35) (b) or (c), 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, 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 (35) (b), 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 has not withheld any information or concealed any facts in completing the enrollment form; however, the enrollee may be required to state that his 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 prepares and shall set down in each such form all material information disclosed to him 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 without undue delay each enrollment form for insurance received by it.

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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 subs. 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 par. (a) 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 par. (a) 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 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.

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 par. (b) 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:

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.

(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 (35) (c) 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:

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 par. (b) 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:

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.

(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.

**Ins 3.32 Title insurance; prohibited practices.** (1) **PURPOSE.** This rule implements and interprets s. 601.01 (3) 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

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3. Any agent, representative, attorney or employe 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 section Ins 6.75 (2) (h) and their affiliates, and includes all officers, employes 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.

(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 employe 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 in-



curred 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) and s. Ins 6.61 (2m), 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.

**Ins 3.38 Coverage of newborn infants. (1) PURPOSE.** This section is intended to interpret and implement s. 632.91, 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, ser-

vices 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 continuing 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. 632.91 (3), 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.

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(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. 632.91 (1), (2), (3) and (4), 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. 632.91, 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. 632.91, Stats.

History: Cr. Register, February, 1977, No. 254, eff. 3-1-77; reprinted, Register, April, 1977, No. 256, to restore dropped text.

**Ins 3.39 Standards for disability insurance sold to the Medicare eligible.**

(1) **PURPOSE.** (a) This section establishes requirements for health insurance policies sold to Medicare eligible persons as required by the Medicare Catastrophic Act of 1988. Disclosure provisions are required for other disability policies sold to Medicare eligible persons because such policies have frequently been represented to, and purchased by, the Medicare eligible as supplements to Medicare.

(b) This section seeks to reduce abuses and confusion associated with the sale of disability insurance to Medicare eligible persons by providing for 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 Medicare supplement and Medicare replacement health insurance which is 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 a "Medicare supplement" or as a "Medicare replacement" unless it meets the requirements of this section.

(c) Wisconsin statutes interpreted and implemented by this rule are ss. 185.983 (1m), 600.03, 601.01 (2), 609.01 (2), 625.16, 628.34 (12), 628.38, 631.20 (2), 632.73 (2m), 632.76 (2) (b) and 632.81.

(2) **SCOPE.** This section applies to individual and group disability policies sold 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), 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 predominantly in Wisconsin to the Medicare eligible by reason of age 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.

(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 employes or former employes or both, or for members or former members or both of the labor organizations;

2. A group policy issued to any professional, trade, or occupational association for its members, former members, retired members, or a combination of these if the association:

a. Is composed of individuals all of whom are or had been actively engaged in the same profession, trade, or occupation;

b. Was maintained in good faith for purposes other than obtaining insurance; and

c. Was in existence for at least 2 years prior to the date of its initial offering of the policy to its members, former members, or retired members;

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:

1. A policy providing solely accident, dental, vision, disability income, or credit disability income coverage; or
2. A single premium, non-renewable policy.

(3) DEFINITIONS. In this section:

(a) "Advertisement" has the meaning set forth in s. Ins 3.27 (5) (a).

(af) "Accident," "Accidental Injury" or "Accidental Means" shall be defined to employ "result" language and shall not include words which 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 which 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.

(ag) "Applicant" means:

1. In the case of an individual Medicare supplement policy or subscriber contract, the person who seeks to contract for insurance benefits.

2. In the case of a group Medicare supplement policy or subscriber contract, the proposed certificateholder.

(ah) "Certificate" means any certificate issued under a group Medicare supplement policy, which certificate had been delivered or issued for delivery in this state.

(ai) "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall be defined in relation to its status, facilities and available services.

1. A definition of such a home or facility shall not be more restrictive than one requiring that it:

- a. Be operated pursuant to law;
- b. Be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;
- c. Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;
- d. Provide continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and
- e. Maintain a daily medical record of each patient.

2. The definition of such a home or facility may provide that the term does not include:

a. Any home, facility or part of any home or facility used primarily for rest;

b. A home facility for the care of drug addicts or alcoholics; or

c. A home or facility primarily used for the care and treatment of mental diseases or disorders, or custodial or educational care.

(am) "Health maintenance organization" means an insurer as defined in s. 609.01 (2), Stats.

(b) "Hospital confinement indemnity coverage" means coverage as defined in s. Ins 3.27 (4) (b) 6.

(bl) "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.

1. The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:

a. Be an institution operated pursuant to law, and;

b. Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which charge is made; and

c. Provide 24 hour nursing service by or under the supervision of registered graduate professional nurses (R.N.s).

2. The definition of the term "hospital" may state that the term does not include:

a. Convalescent homes or convalescent, rest or nursing facilities;

b. Facilities primarily affording custodial, educational or rehabilitative care;

c. Facilities for the aged, drug addicts or alcoholics; or

(c) "Medicare" shall be defined in the policy. "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 89-87, 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.

(d) "Medicare eligible expenses" means health care expenses which are covered by Medicare, recognized as medically necessary and reasonable by Medicare, and which may or may not be fully reimbursed by Medicare.

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

(f) "Medicare replacement coverage" means coverage which meets the definition in s. 600.03 (28p), Stats., as interpreted by sub. (2) (a), and which conforms to subs. (4) and (7).

(g) "Medicare supplement coverage" means coverage which meets the definition in s. 600.03 (28r), Stats., as interpreted by sub. (2) (a), and which conforms to subs. (4), (5) and (6).

(gl) "Mental or Nervous Disorders" shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, and mental or emotional disease or disorder of any kind.

(gm) "Nurse" may be defined so that the description of nurse is restricted to a type of nurse, such as a registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.). If the word "nurse," "trained nurse" or "registered nurse" is used without specific instruction, then the use of the term requires the insurer to recognize the services of any individual who qualified under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

(h) "Nursing home coverage" means coverage as described in s. Ins 3.46 (3).

(i) "Outline of coverage" means a printed statement as defined by s. Ins 3.27 (5) (1), which meets the requirements of sub. (4) (b).

(il) "Physician" may be defined by including words such as "duly qualified physician" or "duly licensed physician." The use of such terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when such services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

(im) 1. "Sickness" shall not be defined to be more restrictive than sickness or disease of an insured person which 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 sickness or disease for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

(j) "Specified disease coverage" means coverage which 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.** Except as explicitly allowed by subs. (5) and (7), no disability insurance policy or certificate shall relate its coverage to Medicare or be structured, advertised, or marketed as a Medicare supplement or as a Medicare replacement policy unless:

(a) The policy or certificate:

1. Provides only the coverage set out in sub. (5) or (7) and applicable statutes and contains no exclusions or limitations other than those permitted by sub. (8);

2. Discloses on the first page any applicable pre-existing conditions limitation, contains no pre-existing condition waiting period longer than

6 months and does 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," or "outpatient prescription drugs" which 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) (c);"

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 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 insurer if the insured moves out of the service area;

6. Provides that termination of the policy or certificate shall be without prejudice to a continuous loss which 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;

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;

8. Changes benefits automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors, although there may be a corresponding modification of premiums in accordance with the policy 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) or (7);

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

13. Is approved by the commissioner.



14. Contains no exclusion, limitation, or reduction of coverage for a specifically named or described condition for longer than 6 months 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 insurer shall issue a pro rata refund to the insured or the insured's estate.

(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 insurer obtains written acknowledgement from the applicant that the outline was received;

2. Complies with s. Ins 3.27, including subs. (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) or (7);

5. Is substantially in the format prescribed in Appendix 1 to this section for the appropriate category;

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), (e) and (g), and the optional coverages as set out in sub. (5) (d), (f), (h) and (i), and the annual premiums therefor, substantially in the format of sub. (11) of Appendix 1; and

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) (d), (f), (h) or (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 collected which will be returned to insureds in the form of aggregate benefits under the policy form:

1. Is computed on the basis of anticipated incurred claims and earned premiums for the entire period for which the policy form provides coverage, in accordance with accepted actuarial principles and practices;

2. Complies with the loss ratio standards in sub. (16) (d);

3. Is submitted to the commissioner along with the policy form.

(f) Except as otherwise provided in this subsection, the terms "Medicare supplement," "medigap" and words of similar import may not be used in a policy or in any advertisement or sales presentation for a policy unless the policy conforms to sub. (5) or (7).

(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. (4) (e).

(4m) OPEN ENROLLMENT. Unless the coverage is subject to sub. (7), an insurer may not deny or condition the issuance or effectiveness of, or discriminate in the pricing of, Basic Medicare supplement coverage for which an application is submitted during the 6-month period beginning with the first month in which an individual 65 years of age or older first enrolled for benefits under Medicare Part B on any of the following grounds:

- (a) Health status.

- (b) Claims experience.

- (c) Receipt of health care.

- (d) Medical condition.

(5) AUTHORIZED MEDICARE SUPPLEMENT POLICY AND CERTIFICATE DESIGNATION, CAPTIONS, REQUIRED COVERAGES, AND PERMISSIBLE ADDITIONAL BENEFITS. For a policy or certificate to meet the requirements of sub. (4), 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. A Medicare supplement policy or certificate shall include:

- (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, July, 1991, No. 427"

sioner 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 'Health Insurance Advice for Senior Citizens,' 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, including outpatient psychiatric care, subject to the Medicare Part B calendar year deductible;

5. Home care benefits 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. Nursing home confinement, kidney disease treatment, and diabetes expense coverage as required under s. 632.895 (3), (4) and (6), 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. Insurers 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 eligible expenses for hospitalization not covered by Medicare;

13. Payment in full for all usual and customary expenses for treatment of diabetes required by s. 632.895 (6), Stats. Insurers are not required to duplicate expenses paid by Medicare.

(i) Permissible additional coverage which may be added to the policy as separate riders or amendments. The insurer shall issue a separate rider for each coverage the insurer chooses to offer and each rider shall be priced separately and available for purchase separately.

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). 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 insurer 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 reasonable charges. The benefit period shall be at least 30 days per year. The rider shall be designated as: **FOREIGN TRAVEL RIDER**.

6. Coverage for preventive health care services such as routine physical examinations, immunizations, health screenings, and in-hospital private duty nursing services. If offered, these benefits shall be included in the basic policy.

7. At least 75% of the usual and customary charges for outpatient prescription drugs after a deductible of no greater than \$100 per year. The rider shall be designated as: **OUTPATIENT PRESCRIPTION DRUG USUAL AND CUSTOMARY CHARGES RIDER**.

(6) **USUAL, CUSTOMARY AND REASONABLE CHARGES.** If an insurer includes a policy provision limiting benefits to the usual, customary and reasonable charge as determined by the insurer, the insurer 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 policy form issued by an insurer who has a cost contract with Health Care Financing Administration for Medicare Part B benefits shall meet the standards and requirements of subs. (4) and (5), except that the commissioner may, at the request of an insurer, approve variations of the coverages specified under sub. (5).

(b) For a Medicare replacement policy or certificate, other than a policy subject to par. (a), to meet the requirements of sub. (4), it shall contain the authorized designation, caption and minimum required coverage. A health maintenance organization shall place the letters HMO in front of the required designation on any approved Medicare replacement policy. A Medicare replacement policy or certificate shall include:

1. The designation: MEDICARE REPLACEMENT 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 replacement insurance. This policy meets these standards. For an explanation of these standards and other important information, see 'Health Insurance Advice for Senior Citizens' given to you when you bought this policy. Do not buy this policy if you did not get this guide."
3. The following minimum coverage, in addition to Medicare benefits:
  - a. The Medicare Part A hospital deductible;
  - b. Upon exhaustion of all Medicare hospital inpatient psychiatric coverage, at least 175 days per lifetime for inpatient psychiatric hospital care;
  - c. Medicare Part A eligible expenses in a skilled nursing facility for the copayments for the 21st through the 100th day;
  - d. The Medicare Part B deductible and all Medicare Part B eligible expenses, including outpatient psychiatric care, to the extent not covered by Medicare;
  - e. Home care benefits of 40 visits per 12-month period as required under s. 632.895 (1) and (2), Stats., and s. Ins 3.54;
  - f. Nursing home confinement, kidney disease treatment, and diabetes expense coverage as required under s. 632.895 (3), (4) and (6), Stats.;
  - g. In group policies, nervous and mental disorder and alcoholism and other drug abuse coverage as required under s. 632.89, Stats.;
  - h. Payment in full for all usual and customary expenses for chiropractic services required by s. 632.87 (3), Stats. Insurers are not required to duplicate payments made by Medicare;
  - i. Payment in full for all usual and customary expenses for treatment of diabetes required by s. 632.895 (6), Stats. Insurers are not required to duplicate payments made by Medicare;

(c) Each insurer which markets a Medicare replacement policy shall have an approved Medicare supplement insurance policy available for all currently enrolled participants at the time as the contract between the Health Care Financing Administration and the insurer is terminated.

(8) PERMISSIBLE MEDICARE SUPPLEMENT AND MEDICARE REPLACEMENT POLICY OR CERTIFICATE EXCLUSIONS AND LIMITATIONS. (a) The coverage set out in subs. (5) and (7):

1. May 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 insurer may exclude from coverage the expenses which Medicare Part B would have covered if the insured were enrolled in Medicare Part B. An insurer may not exclude Medicare Part B eligible expenses incurred beyond what Medicare Part B would cover.

(c) The coverages set out in subs. (5) and (7) may not exclude, limit, or reduce coverage for specifically named or described pre-existing 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.

(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 'Health Insurance Advice for Senior Citizens', 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 'Health Insurance Advice for Senior Citizens', 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 (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 'Health Insurance Advice for Senior Citizens', 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 insurer, 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 insurer, 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 insurer 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) (c) 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) (1).

(11) "HEALTH INSURANCE ADVICE FOR SENIOR CITIZENS" 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 "Health Insurance Advice for Senior Citizens" at the time the

prospect is contacted by an intermediary or insurer with an invitation to apply as defined in 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 insurer. This pamphlet provides information on Medicare and advice to senior citizens on the purchase of Medicare supplement insurance and other health insurance. Insurers 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 insurer shall be responsible for providing applicants the revised pamphlet until 30 days after the insurer 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) of this section, 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), Stats., shall not be subject to:

(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; and

(b) The special pre-existing diseases provision for Medicare supplement policies set forth in s. 632.76 (2) (b), Stats.

(14) **OTHER REQUIREMENTS.** (a) Each insurer may file and utilize only one individual Medicare supplement 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 insurer agrees to aggregate experience for the various forms in calculating rates and loss ratios.

(b) An insurer 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) Insurers issuing Medicare supplement policies shall comply with all provisions of Section 4081 of the Omnibus Budget Reconciliation Act of 1987 and shall annually certify on the Medicare Supplement Experience Exhibit that it has complied with these requirements.

(15) **FILING REQUIREMENTS FOR ADVERTISING.** Prior to use in this state, every insurer shall file with the commissioner a copy of any advertisement used in connection with the sale of Medicare supplement policies issued with an effective date after December 31, 1989. If the advertisement does not reference a particular insurer or Medicare supplement policy, each agent utilizing the advertisement shall file the advertisement with the commissioner prior to using it. Insurers and agents shall submit the advertisements using forms specified in Appendices 2 and 3. The advertisements shall comply with all applicable laws and rules of this state.



(16) **LOSS RATIO REQUIREMENTS FOR EXISTING POLICIES.** (a) Every insurer providing Medicare supplement policies in this state shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by number of years of policy duration demonstrating that it is in compliance with the applicable loss ratio standards contained in par. (d) and that the period for which the policy is rated is reasonable in accordance with accepted actuarial principles and experience.

(b) For the purposes of this section, a policy shall be deemed to comply with the loss ratio standards if:

1. For the most recent year, the ratio of the incurred losses to earned premiums for policies or certificates which have been in force for 3 years or more is greater than or equal to the applicable percentages under par. (d); and

2. The expected losses in relation to premiums over the entire period for which the policy is rated comply with the requirements of par. (d). 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 Medicare benefit changes, every insurer providing Medicare supplement insurance or contracts in this state shall file with the commissioner in accordance with the applicable filing procedures of this state:

1. a. Appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the applicable policies or contracts. Supporting documents as necessary to justify the adjustment shall accompany the filing.

b. Every insurer providing Medicare supplement insurance or benefits to a resident of this state shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or contract as will conform with minimum loss ratio standards for Medicare supplement 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 insurer for such Medicare supplement insurance policies or contracts. 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. Premiums adjustments shall be in the form of refunds or premium credits and shall be made no later than upon renewal if a credit is given, or within 60 days of the renewal date or anniversary date if a refund is provided to the premium payer. Premium adjustments shall be calculated for the period commencing with Medicare benefit changes.

2. Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement insurance modifications necessary to eliminate benefit duplications with Medicare. Any riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided provided by the policy or contract.

(d) For purposes of sub. (4) (e) and par. (b), 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.

(17) **BENEFIT CONVERSION REQUIREMENTS DURING TRANSITION.** (a) Effective January 1, 1990, no Medicare supplement insurance policy, contract or certificate in force in this state shall contain benefits which duplicate benefits provided by Medicare.

(b) Benefits eliminated by operation of the Medicare Catastrophic Coverage Act of 1988 transition provisions shall be restored.

(c) For Medicare supplement policies subject to the minimum standards adopted pursuant to Medicare Catastrophic Coverage Act for 1988, the minimum benefits shall be no less than those specified in sub. (5) (c).

(18) **NOTICE REQUIREMENTS TO EXISTING POLICYHOLDERS.** (a) No later than January 31, 1990, every insurer providing Medicare supplement insurance or benefits to a resident of this state shall notify its policyholders, contractholders and certificateholders of modifications it has made to its Medicare supplement insurance policies or contracts. Such notice shall be in the format shown in Appendix 4 and 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 insurance policy or contract.
2. Inform each covered person as to when any premium adjustment due to changes in Medicare benefits will be effective.
3. Be in outline form and in clear and simple terms so as to facilitate comprehension for the notice of benefit modifications and any premium adjustments.
4. Not contain or be accompanied by any solicitation.

(b) No modifications to an existing Medicare supplement contract or policy shall be made at the time of or in connection with the notice requirements of this regulation except to the extent necessary to accomplish the purposes articulated in this subsection.

(19) **FORM AND RATE FILING REQUIREMENTS FOR EXISTING POLICIES.**

(a) Every insurer providing Medicare supplement insurance or contracts in this state shall file with the commissioner, in accordance with the applicable filing procedures of this state:

1. Appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the applicable policies or contracts. Such supporting documents as necessary to justify the adjustment shall accompany the filing prior to January 31, 1990.
2. Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement insurance modifications necessary to eliminate benefit duplications with Medicare and to provide the benefits required by the this section prior to January 15, 1990. Any such riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or contract.

(b) Upon satisfying the filing and approval requirements of this state, every insurer providing Medicare supplement insurance in this state

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shall provide each covered person with any rider, endorsement or policy form necessary to make the adjustments outlined in sub. (18).

(c) Any premium adjustments shall produce an expected loss ratio under such policy or contract as will conform with the minimum loss ratio standards for Medicare supplement policies and shall result in an expected loss ratio at least as great as that originally anticipated by the insurer, health care service plan or other entity for such Medicare supplement insurance policies or contracts. Premium adjustments may be calculated for the period commencing with the Medicare benefit changes.

(d) Insurers may adjust the premium charged to policies referenced in pars. (a), (b) and (c) retroactive to January 1, 1990, providing the insurer files the proposed rate change with the commissioner prior to January 30, 1990, and notifies the insured in writing no later than January 31, 1990.

(20) OFFER OF REINSTITUTION OF COVERAGE. (a) Except as provided in par. (b), in the case of an individual who had in effect, as of December 31, 1988, a Medicare supplemental policy with an insurer (as a policyholder or, in the case of a group policy, as a certificateholder) and the individual terminated coverage under such policy before January 1, 1990, the insurer shall:

1. Provide written notice no later than January 30, 1990, to the policyholder or certificateholder at the most recent available address of the offer described in subd. 2, and

2. Offer the individual, prior to April 1, 1990, reinstatement of coverage with coverage effective as of January 1, 1990, under the terms which:

a. Does not provide for any waiting period with respect to treatment of pre-existing conditions;

b. Provides for coverage which is substantially equivalent to coverage in effect before the date of such termination; and

c. Provides for classification of premiums on which terms are 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 never terminated.

(b) An insurer is not required to make the offer under par. (a) in the case of an individual who is a policyholder or certificateholder in another Medicare supplemental policy as of January 1, 1990, if the individual is not subject to a waiting period with respect to treatment of a pre-existing condition under such other policy.

(21) COMMISSION LIMITATIONS. (a) An insurer may provide and an agent or other representative may accept commission or other compensation for the sale of a Medicare supplement 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 insurer 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.

(22) REQUIRED DISCLOSURE PROVISIONS. (a) Medicare supplement policies 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.

(b) Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits; all riders or endorsements added to a Medicare supplement 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 issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement 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.

(c) A Medicare supplement policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

(d) If a Medicare supplement policy contains any limitations with respect to pre-existing conditions, such limitations must appear on the first page.

(e) Medicare supplement policies or certificates shall have a notice prominently printed on the first page of the policy or 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, every insurer, health care service plan or other entity providing Medicare supplement insurance or benefits to a resident of this state shall notify its policyholders, contractholders and certificateholders of modifications it has made to Medicare supplement insurance policies or contracts 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 insurance policy or contract, and

2. Inform each covered person 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.

(23) REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE. (a) Application forms for Medicare supplement 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 questions:

1. Do you have another Medicare supplement insurance policy or certificate in force (including health care service contract or health maintenance organization contract)?

2. Did you have another Medicare supplement policy or certificate in force during the last twelve (12) months?

a. If so, with which company?

b. If that policy lapsed, when did it lapse?

3. Are you covered by Medicaid?

4. Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

(b) Agents shall list, in a supplementary form signed by the agent and submitted to the insurer 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.

(c) Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of accident and sickness coverage. 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 be retained by the insurer. A direct response insurer 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 insurer, other than a direct response insurer, shall be provided in substantially the form as shown in Appendix 5. Direct response insurers shall use a notice in substantially the form as shown in Appendix 6.

(24) **STANDARDS FOR MARKETING.** (a) Every insurer 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 insurer 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 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.

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 insurer.

(d) Every insurer shall establish marketing procedures which set forth a mechanism or formula for determining whether a replacement policy or certificate contains benefits clearly and substantially greater than the benefits under the replaced policy.

(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 insurer shall mail the entire premium refund directly to the person who paid the premium.

(25) **APPROPRIATENESS OF RECOMMENDED PURCHASE AND EXCESSIVE INSURANCE.** (a) In recommending the purchase or replacement of any

Medicare supplement 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 coverage which will provide an individual more than one Medicare supplement policy or certificate is prohibited.

(c) An agent shall forward each application taken for a Medicare supplement policy to the insurer within 7 calendar days after taking the application. An agent shall mail the portion of any premium collected due the insurer to the insurer within 7 days after receiving the premium.

(26) REPORTING OF MULTIPLE POLICIES. (a) On or before March 1 of each year, every insurer providing Medicare supplement 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 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.

(27) WAITING PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing insurer shall waive any time periods applicable to pre-existing condition waiting periods in the new Medicare supplement policy for similar benefits to the extent time was satisfied under the original policy.

(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 insurer 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 insurer 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 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 shall not result in any limitation for pre-existing conditions that would have been covered under the group policy being replaced.

(29) Every insurer of group Medicare supplement insurance benefits to a resident of this state shall file a copy of the master policy and any certifi-

icate used in this state in accordance with the filing requirements and procedures applicable to group Medicare supplement policies issued in this state; provided, however, that no insurer shall be required to make a filing earlier than 30 days after insurance was provided to a resident of this state under a master policy issued for delivery outside this state.

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: Section (4m), (5) (c) 8 and 13 and (i) (intro.), 1 to 5 and 7, (7) (except (7) (c) 3, as renumbered), and, (16) (a), (b), and (d), as affected by Register No. 427, first apply to policies issued on or after January 1, 1992.

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. am. (1)(a), (3)(ag), (ah), (im), (4)(intro.), (a) 1, 3, 5, 10, 14 and 18. b., (4)(b) 4., 5. and 7., (c) 3., (e), (g) 2., (4m), (5)(i) (intro.), 5. and 7., (8)(a) (intro.), 1. and (c), (11), (16), (22)(a) to (f), (23) (a), (c) and (d), (26)(b) - (27) and Appendices 4, 6 and 11, or (2)(a) 5., (3)(aj), (ac), (bm), (ij), (ik), (4)(a) 16., 17. and 18., (4), (5)(g), (4)(d) to (g), (23) (b) 2., (24)(g), (30) to (33) and Appendix 7, renum. (2)(jm) and (5)(i) 6., (7)(d) Register, July, 1991, No. 427 renum. from Ins 3.13 (2)(jm), 12. (3)(ai), (bl), (gl), (gm) and (il), (4)(f), (17) 6 (20) (24)(d) and Appendix 2 (2)(a), r. and recr. (14)(e), (29) Appendix 1 (i) and 6 - 136-1-92*



## Ins 3.39 Appendix I

(COMPANY NAME)  
OUTLINE OF MEDICARE SUPPLEMENT INSURANCE  
or  
OUTLINE OF MEDICARE REPLACEMENT INSURANCE  
(The designation and caption required by sub. (4) (b) 4)

(1) Read Your Policy Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. READ YOUR POLICY CAREFULLY!

(2) (a) The outline of coverage for a Medicare supplement insurance policy shall contain the following language:

Medicare Supplement Insurance Policy: This policy supplements Medicare. It covers some hospital, skilled nursing facility, medical, surgical, and other outpatient services which are partially covered by Medicare. It will not cover all your health care expenses. 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.

(b) The outline of coverage for a Medicare replacement insurance policy 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.

(3) (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:

(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).

(4) (a) For Medicare supplement policies, provide a brief summary of the major benefits and gaps in Medicare Parts A & B with a parallel description of supplemental benefits, including dollar amounts, as outlined in these charts.

(b) For Medicare replacement policies, 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.

## WISCONSIN ADMINISTRATIVE CODE

## MEDICARE SUPPLEMENT POLICIES—PART A BENEFITS

(Insurers should include only the wording which applies to their policy's "This Policy Pays" column and complete the "You Pay" column)

Medicare Part A Benefits	Per Benefit Period	Medicare Pays	This Policy Pays	You Pay
Hospitalization. Semiprivate room and board, general nursing and miscellaneous hospital services and supplies. Includes meals, special care units, drugs, lab tests, diagnostic x-rays, medical supplies, operating and recovery room, anesthesia and rehabilitation services.	First 60 days	All but \$(current deductible)	\$0 or (\$ ) or <input type="checkbox"/> 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	Nothing	All	
Skilled nursing care in a facility approved by Medicare. Confinement must meet Medicare standards. You must have been in a hospital for at least three days and enter the facility within 30 days after discharge.	First 20 days	100% of costs	\$0	
	Additional 80 days	All but \$(current amount per day)	\$(current amount per day)	
Inpatient psychiatric care in a participating psychiatric hospital		190 days per lifetime	175 additional days per lifetime	
Blood		All but 1st 3 pints	First 3 pints	
Home health care		100% of charges for visits considered medically necessary by Medicare	40 visits or 365 visits or <input type="checkbox"/> OPTIONAL ADDITIONAL HOME HEALTH CARE RIDER*	

\*These are optional riders. You purchased this benefit if the box is checked and you paid the premium.

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Ins 3

MEDICARE SUPPLEMENT POLICIES—PART B BENEFITS

Medicare Part B Benefits	Per Calendar Year	Medicare Pays	This Policy Pays	You Pay
Medical expenses. Eligible expenses for physician's services, in-patient and out-patient medical services and supplies at a hospital, physical and speech therapy, ambulance, and outpatient psychiatric care	Initial (\$ ) deductible  After initial deductible	\$0  80% of Medicare approved charge	Nothing or (\$ ) or <input type="checkbox"/> OPTIONAL PART B DEDUCTIBLE RIDER*  20% of Medicare approved charge or The difference between what Medicare pays and the excess charge or <input type="checkbox"/> OPTIONAL MEDICARE PART B EXCESS CHARGES RIDER*	
Outpatient prescription drugs		\$0	\$0 or 75% of outpatient prescription drugs with a deductible of \$ (not more than \$100) or <input type="checkbox"/> OPTIONAL OUTPATIENT PRESCRIPTION DRUG USUAL AND CUSTOMARY CHARGES RIDER*	
Blood		80% of costs except nonreplacement fees (blood deductible) for first 3 pints (after \$ deductible/ calendar year)	20% of all costs and the first 3 pints in each calendar year	
Immunosuppressive drugs		80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant (after \$ deductible/ calendar year)	20% of allowable charges for immunosuppressive drugs	
Part B policy limits per calendar year			No limit	

\*These are optional riders. You purchased this benefit if the box is checked and you paid the premium.

(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 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 40 visits mandated by s. 632.895 (2), Stats.

(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).

(j) Usual, customary, and reasonable limitations.

(6) Conspicuous statements as follows:

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

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

(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:

#### MEDICARE SUPPLEMENT PREMIUM INFORMATION

Annual Premium

\$( ) BASIC MEDICARE SUPPLEMENT POLICY

#### OPTIONAL BENEFITS FOR MEDICARE SUPPLEMENT POLICY

Each of these riders may be purchased separately.

(Note: Only optional coverages provided by rider shall be listed here.)

\$( ) 1. Part A deductible  
100% of Part A deductible

\$( ) 2. Additional home health care  
An aggregate of 365 visits per year including those covered by Medicare

\$( ) 3. Part B deductible  
100% of Part B deductible

\$( ) 4. Part B excess charges

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Difference between what Medicare pays and the amount charged by the provider which shall be no greater than the actual charge or the limiting charge allowed by Medicare, whichever is less

- \$( ) 5. Usual and customary outpatient prescription drug charges  
75% of the usual and customary charges after a deductible of \$  
\_\_\_\_ (no more than \$100)
- \$( ) 6. Foreign travel rider  
After a deductible not greater than \$250, covers at least 80% of  
expenses associated with medical care received outside the  
U.S.A. for a minimum of 30 days

\_\_\_\_\_  
\$( ) 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.)

IN ADDITION TO THIS OUTLINE OF COVERAGE, [INSURANCE COMPANY] WILL SEND AN ANNUAL NOTICE TO YOU 30 DAYS PRIOR TO THE EFFECTIVE DATE OF MEDICARE CHANGES WHICH 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 insurer shall give a separate schedule of premiums for each rating classification with the outline of coverage.

(13) 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.

**Next page is numbered 150-7**

APPENDIX 2

ADVERTISING  
CERTIFICATE OF COMPLIANCE

I, \_\_\_\_\_ (name), an offer of \_\_\_\_\_ (company name) hereby certify that I have authority to bind and obligate the company by filing this (these) advertisement(s). I further certify that, to the best of my information, knowledge, and belief:

(Note: If the advertisement is filed by an agent, then use the following paragraph as the first paragraph:)

I, \_\_\_\_\_, insurance agent, hereby certify that to the best of my information, knowledge, and belief:

1. I have reviewed Wisconsin Statutes and administrative rules and the accompanying advertisement(s) as identified by the attached listing comply(ies) with all applicable provisions of the Wisconsin Statutes and with all applicable administrative rules of the Commissioner of Insurance;

2. The advertisement(s) does (do) not contain any inconsistent, ambiguous, or misleading language;

3. The attached advertisement(s) is (are) in final printed format or typed facsimile and is (are) as will be used in Wisconsin.

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(title)

\_\_\_\_\_  
(date)

Individual responsible for this filing:

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date: \_\_\_\_\_

WISCONSIN ADMINISTRATIVE CODE

APPENDIX 3

Bureau of Market Regulation  
OFFICE OF THE COMMISSIONER OF INSURANCE  
P.O. Box 7873  
Madison, Wisconsin 53707-7873

Ref. s. Ins 3.39 (15), Wis Adm. Code

ADVERTISING FORM TRANSMITTAL

PLEASE REFER TO INSTRUCTIONS WHEN COMPLETING FORM. The instructions may be obtained from the Insurance Commissioner's office at the above address.

1. Company OCI Number □□ - □□□□ □□□ - □	FOR OCI USE ONLY
1a. Agent OCI License Number □□□□□□	2. Submission Number □□□□□□□□
3. Company/Agent Name and Mailing address	4. Individual Responsible for This filing
	5. Telephone Number

6. Advertisement Title

7. Form Number [s. Ins 3.27 (26)]

8. Coverage Class	9. Code	10. Type of Advertising
(Numeric)	(Alpha)	(Alpha)


(If more space is required, use additional forms.)

11.  Certificate of Compliance — Ref. Ins 3.39 (15)

OCI 26-16 (08-88)

APPENDIX 4

(COMPANY NAME)

NOTICE OF CHANGES IN MEDICARE AND YOUR MEDICARE SUPPLEMENT COVERAGE — 1990

THE FOLLOWING CHART BRIEFLY DESCRIBES THE MODIFICATIONS IN MEDICARE AND IN YOUR MEDICARE SUPPLEMENT COVERAGE. PLEASE READ THIS CAREFULLY!

[A BRIEF DESCRIPTION OF THE REVISIONS TO MEDICARE PARTS A & B WITH A PARALLEL DESCRIPTION OF SUPPLEMENTAL BENEFITS WITH SUBSEQUENT CHANGES, INCLUDING DOLLAR AMOUNTS, PROVIDED BY THE MEDICARE SUPPLEMENT COVERAGE IN SUBSTANTIALLY THE FOLLOWING FORMAT.]

SERVICES	MEDICARE BENEFITS		YOUR MEDICARE SUPPLEMENT COVERAGE	
	In 1989 Medicare Pays Per Benefit Period	Effective January 1, 1990, Medicare Will Pay	In 1989 Your Coverage Pays	Effective January 1, 1990, Your Coverage Will Pay Per Calendar Year
<b>MEDICARE PART A SERVICES AND SUPPLIES</b>				
In patient Hospital Services	Unlimited number of hospital days after \$560 deductible	All but \$592 for the first 60 days/benefit period		
Semi-Private Room & Board		All but \$148 a day for 61st-90th days/benefit period		
Misc. Hospital Services & Supplies, such as Drugs, X-Rays, Lab Tests & Operating Room		All but \$296 a day for 91st-150th days (if individual chooses to use 60 nonrenewable lifetime reserve days)		
<b>BLOOD</b>	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	pays all costs except nonreplacement fees (blood deductible) for first 3 pints of each benefit period		
<b>SKILLED NURSING FACILITY CARE</b>	There is no prior confinement requirement for this benefit	100% of costs for 1st 20 days (after a 3-day period hospital confinement)/benefit period		
	First 8 days - all but \$25.50 a day	All but \$74.00 a day for 21st-100th days/benefit period		



WISCONSIN ADMINISTRATIVE CODE

SERVICES	MEDICARE BENEFITS		YOUR MEDICARE SUPPLEMENT COVERAGE	
	In 1989 Medicare Pays Per Benefit Period	Effective January 1, 1990, Medicare Will Pay	In 1989 Your Coverage Pays	Effective January 1, 1990, Your Coverage Will Pay Per Calendar Year
	9th through 150th day - 100% of costs period	Beyond 100 days - nothing/benefit		
	Beyond 150 days - nothing			
MEDICARE PART B SERVICES AND SUPPLIES	80% of allowable charges (after \$75 deductible calendar year)	80% of allowable charges (after \$75 deductible)		
PRESCRIPTION DRUGS	Inpatient prescription drugs. 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant (after \$75 deductible/calendar year)	Inpatient prescription drugs. 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant (after \$75 deductible/calendar year)		
BLOOD	80% of all costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period (after \$75 deductible/calendar year)	80% of costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period (after \$75 deductible/calendar year)		

[Any other policy benefits not mentioned in this chart should be added to the chart in the order prescribed by the outline of coverage benefits, they should be shown.]

[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 SUMMARIZING THE CHANGES IN YOUR MEDICARE BENEFITS AND IN YOUR MEDICARE SUPPLEMENT PROVIDED BY (COMPANY) ONLY BRIEFLY DESCRIBES SUCH BENEFITS. FOR INFORMATION ON YOUR MEDICARE BENEFITS CONTACT YOUR SOCIAL SECURITY OFFICE OR THE HEALTH CARE FINANCING ADMINISTRATION. FOR INFORMATION ON YOUR MEDICARE SUPPLEMENT POLICY CONTACT:

[COMPANY OR FOR AN INDIVIDUAL POLICY — NAME OF AGENT]  
[ADDRESS/PHONE NUMBER]

APPENDIX 5

**NOTICE TO APPLICANT REGARDING REPLACEMENT OF  
MEDICARE SUPPLEMENT 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 medicare supplement insurance and replace it with a 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 which 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 coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this medicare supplement 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 which 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 original policy.
3. If you are replacing existing medicare supplement insurance coverage, you may wish to secure the advise 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 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, reread it carefully to be certain that all requested information has been properly reported.

\_\_\_\_\_  
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:

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Applicant's Signature)

APPENDIX 6

The replacement notice for direct response insurer shall be as follows:

**NOTICE TO APPLICANT REGARDING REPLACEMENT OF  
MEDICARE SUPPLEMENT 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 medicare supplement insurance and replace it with the 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 which 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 coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this medicare supplement coverage is a wise decision.

1. Health conditions which you may presently have (preexisting 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 pre-existing condition waiting periods. The insurer will waive any time periods applicable to pre-existing condition waiting 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 medicare supplement 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 30 days if any requested information is not correct and complete, or if any requested past medical history has been left out of the application.

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(Company Name Agent)

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

(b) A Coordination of benefits (COB) provision as defined in sub. (3) (e) avoids claim payment delays by establishing an order in which Plans pay their claims and by providing the authority for the orderly transfer of information needed to pay claims promptly. It avoids duplication of benefits by permitting a reduction of the benefits of a Plan when, by the rules established by this section, a Plan does not have to pay its benefits first.

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

(2) **SCOPE.** This section applies to 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) (b), 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 subs. 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 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  
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provides benefits only for these items may limit its definition of allowable expense to these items of expense.

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

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

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

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

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

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

(b) The definition of Plan shown in the model COB provision in APPENDIX A is an example of what may be used. Any definition that satisfies sub. (3) (i) and this 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 employe or the employe's covered dependent has health care coverage under more than one Plan.

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

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

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

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

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

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

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

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

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

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

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

1. Another Plan exists;
2. Except with respect to Part B of Medicare, that a person is or could have been covered under another Plan; or
3. A person has elected an option under another Plan providing a lower level of benefits than another option which could have been elected.

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



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

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

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

1. 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 employe, member or subscriber are determined before those of the Plan that covers the person as a dependent of an employe, member or subscriber.

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

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

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

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

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 subpar. a. 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. a. 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.

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

- 1) A change in the amount or scope of a Plan's benefits;
- 2) A change in the entity which pays, provides or administers the Plan's benefits; or
- 3) A change from one type of Plan to another, such as, from a single employer plan to that of a multiple employer plan.

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

(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 second-

ary 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 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.

*Applicability.* 1) Except as provided in 2), the treatment of s. Ins 3.40 (2), (12) and (13) by this October, 1991 rule revision first applies to a group contract providing health care benefits:

a) For group contracts that are issued or renewed on January 1, 1992, on the effective date of this rule.

b) For group contracts that are issued or renewed after January 1, 1992, on the date of issuance or the first anniversary or renewal date following the effective date of this rule.

2) If a group contract providing health care benefits is written pursuant to a collectively bargained agreement, the treatment of s. Ins 3.40 (2), (12) and (13) by this October, 1991 rule revision first applies on whichever of the following occurs later:

a) January 1, 1992.

b) The expiration date of the collectively bargained agreement pursuant to which the group contract was written if the agreement prohibits changes to the health care benefits prior to its expiration date.

**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.

## 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.

(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.

**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. This subsection does not apply to a long-term care policy as defined under s. Ins 3.46 (3) (e).

(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.

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**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.

Ins 3

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Ins 3.44 Effective date of s. 632.897, Stats.** (1) Section 632.897, Stats., applies to group policies issued or renewed on or after May 14, 1980, or if Register, April, 1991, No. 424

a policy is not renewed within 2 years after the effective date of the act, s. 632.897, Stats., is effective at the end of 2 years from May 14, 1980.

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

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

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

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

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

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

**Ins 3.455 Long-term care, nursing home and home health care policies; loss ratios; 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

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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) (a).

(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) "Life insurance-long-term care coverage" has the meaning provided under s. Ins 3.46 (3) (d).

(b) "Long-term care policy" has the meaning provided under s. Ins 3.46 (3) (e).

(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 (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) MINIMUM LOSS RATIO REQUIREMENTS FOR LONG-TERM CARE, NURSING HOME AND HOME HEALTH CARE POLICIES. (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.

(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.

(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 which 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 which is identical to 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 which:

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; and
4. Provides coverage of care in a community-based setting, if the original policy provided coverage in a community-based setting.

(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.



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

(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 which:

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

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) "Compensation" means remuneration of any kind, including, but not limited to, pecuniary or nonpecuniary remuneration, commissions, bonuses, gifts, prizes, awards, finder's fees, and policy fees.

(b) "Guaranteed renewable for life" means a policy renewal provision which continues the insurance in force unless the premium is not paid on time, which 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 which 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.

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

(d) "Life insurance-long-term care coverage" means coverage which:

1. Provides coverage for convalescent or custodial care or care for a chronic condition or terminal illness; and

2. Is included in a life insurance policy or an endorsement or rider to a life insurance policy.

(e) "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:

1. A medicare supplement policy or 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, Stats.

4. Life insurance-long-term care coverage.

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

(g) "Medicare eligible persons" means persons who qualify for medicare.

(h) "Outline of coverage" means a document which gives a brief description of benefits in the format prescribed in Appendix 1 to this section and which complies with sub. (8).

(i) "Guide to long-term care" means the pamphlet prescribed by the commissioner which provides information on long-term care insurance and advice to consumers on the purchase of long-term care insurance.

(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 \$30 per day.

(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.

(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. If the form requires that care be provided according to a plan of care, that benefits are available only based on ability to perform activities of daily living, or that benefits are available or vary according to the level of care, the form shall also provide that, in the absence of fraud and collusion, the attending physician's certification of any of those matters is conclusive.

(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," "intermediate care," "personal care," or "home care" services, if those terms are used, in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

(k) Define terms used to describe providers whose services are covered, including, but not limited to, "skilled nursing facility," "extended care facility," "intermediate care facility," "convalescent nursing home," "personal care facility" and "home care agency," if those terms are used, in relation to the services and facilities required to be available and the licensing or degree status of those providing or supervising the services. A definition may require that a provider be appropriately licensed or certified. A form may not exclude coverage of any type of service normally provided by the defined provider, facility or agency.

(l) Clearly disclose any limitations of the coverage.

(m) Not exclude or limit coverage by type of illness, treatment, medical condition or accident, except it may include exclusions or limits for:

1. Preexisting conditions or diseases;
2. Illness, treatment or medical condition arising out of any one or more of the following:

a. Treatment provided in a government facility, unless coverage is otherwise required by law.

b. Services for which benefits are available under medicare or a governmental program other than medicaid, or under a state or federal worker's compensation, employer's liability, occupational disease or 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.

(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:

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.

(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.

(5) FORM REQUIREMENTS FOR LONG-TERM CARE, NURSING HOME AND HOME HEALTH CARE POLICIES ONLY. (a) This subsection and ss. Ins 3.13 (2) (h) 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.

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. THIS OUTLINE OF COVERAGE PROVIDES A BRIEF DESCRIPTION OF BENEFITS. 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.

(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) (1) 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, Register, April, 1991, No. 424

advertising, marketing or offer the outline of coverage is approved in writing by the office.

(9) **DISCLOSURE WHEN SOLICITING.** 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:

- (a) A copy of the current edition of the guide to long-term care; and
- (b) An outline of coverage.

(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.

(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 an 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.

(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.

(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

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 shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(c) Application forms for long-term care policies or certificates 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 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 such questions may be used.

1. Do you have another long-term care, nursing home or home health care policy or certificate in force (including a health maintenance organization policy or certificate)?

2. Did you have another long-term care, nursing home or home health care policy or certificate in force during the last 12 months?

a. If so, with which company?

b. If the policy or certificate lapsed, when did it lapse?

3. Are you covered by Medicaid?

4. Do you intend to replace any of your medical or health insurance coverage with this policy or certificate?

(d) An intermediary taking an application for a long-term care policy or certificate shall:

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; and

4. Submit the lists to the insurer with the application.

(e) Section Ins. 3.29 applies to the solicitation and sale of long-term care policies and certificates.

(f) Every insurer and person marketing long-term care insurance coverage in this state, directly or through its producers, shall:

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 accident and sickness or a long-term care policy or certificate and the types and amounts of any such insurance.

4. Establish auditable procedures for verifying compliance with this paragraph.

(g) No person may:

1. Knowingly make any misleading representation or incomplete or fraudulent comparison of any insurance policies, certificates 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, certificate or to take out a policy of insurance or certificate with another insurer.

2. Employ 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. Make 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.

(h) 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.

(i) In regards to any transaction involving a long-term care policy or certificate, 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.

(j) 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.

**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.

Ins 3.46 Appendix I

(COMPANY NAME)

OUTLINE OF COVERAGE

(Insert the appropriate caption stated below.)

LONG-TERM CARE INSURANCE POLICY

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. THIS OUTLINE OF COVERAGE PROVIDES A BRIEF DESCRIPTION OF BENEFITS. READ YOUR POLICY CAREFULLY.

or

NURSING HOME INSURANCE POLICY

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. THIS OUTLINE OF COVERAGE PROVIDES A BRIEF DESCRIPTION OF BENEFITS. READ YOUR POLICY CAREFULLY.

or

HOME HEALTH CARE INSURANCE POLICY

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. THIS OUTLINE OF COVERAGE PROVIDES A BRIEF DESCRIPTION OF BENEFITS. READ YOUR POLICY CAREFULLY.

plus

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.

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

(a) Pre-existing condition limitation

- (b) Elimination periods
  - (c) Exclusions and limitations in the policy
  - (d) Prior authorization procedures
  - (e) Benefit periods and lifetime maximums in the policy
  - (f) Renewability provision of the policy
  - (g) "Free look" provisions of the policy
  - (h) Inflation protection provisions
  - (i) Definitions for skilled, intermediate and custodial care, activities of daily living, home health care, and respite care
  - (j) Benefit appeals internal procedures.
- (2) The outline shall contain a statement that the policy will provide benefits for persons with irreversible dementia if the person requires the type of care covered by the policy and is otherwise eligible for benefits.
- (3) A summary of the costs of the policy and any optional rider purchased. The summary may be completed at the time the outline is provided to an applicant.
- (4) For life insurance products, a statement that the cash value and death benefits will be reduced if claims are paid under life insurance-long-term care coverage.

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

(2) **PURPOSE.** 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

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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.

Note: The amendment to subs. (2) to (5) applies to solicitations for cancer insurance on and after January 1, 1991.

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.

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:

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WISCONSIN ADMINISTRATIVE CODE

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.

**Ins 3.48 Preferred provider plans.** (1) **SCOPE.** This section applies to all preferred provider plans as defined in s. 609.01 (4), Stats.

(2) **DEFINITIONS.** In this section:

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(a) "Complaint" means any dissatisfaction about an insurer or its contracted providers expressed by an enrollee.

(b) "Grievance" means any dissatisfaction with the administration or claims practices of or provision of services by a preferred provider plan which is expressed in writing by or on behalf of a plan enrollee.

(3) EXCESSIVE DISTANCES. (a) Except as provided in pars. (b) and (c), preferred provider plans shall offer coverage to a person only if preferred providers of primary care services and emergency services are available within 30 minutes' travel time of the person's place of residence.

(b) A preferred provider plan may offer coverage on a group basis to an employer for its employees or to an employee organization without taking into account the places of residence of the employees, if preferred providers of primary care services and emergency services are available either within the county or within 30 minutes' travel time of the employment location.

(c) A preferred provider plan may provide coverage to a person without taking into account the person's place of residence or employment if the person is informed in writing of the services covered and the location of all preferred providers and makes a written request for coverage.

(4) CONTINUITY OF PATIENT CARE. (a) Subject to pars. (b), (c), (d) and (e), a preferred provider plan which is offered on a group basis to an employer for its employees or to an employee organization shall extend enrollment periods for group members and their families who wish to be enrolled in the plan, but who are in a course of treatment with a provider not selected by the plan and wish to continue that course of treatment. Enrollment standards for those who request an extended enrollment period shall be no more restrictive than they are for those who enroll during the normal enrollment period.

(b) A preferred provider plan may require a group member to request an extended enrollment period during the normal enrollment period specified by the plan and to indicate the nature and the expected duration of the course of treatment.

(c) A preferred provider plan is not required to extend enrollment opportunities to a dependent of a group member unless the group member and any other dependents also receive an extension.

(d) A preferred provider plan may limit the extension of the enrollment period for a group member and dependents to 90 days after the effective date of the contract.

(e) A preferred provider plan shall receive no premiums and bear no responsibility for coverage of group members and their dependents until they are enrolled.

(f) When a person changes from one plan to another, the responsibilities of the prior and succeeding insurers outlined in s. Ins 6.51 (6), (7) and (8) shall apply.

(5) SUBSTANTIALLY EQUIVALENT BENEFITS DEFINED. (a) For purposes of s. 609.10 (1) (a), Stats., plans will be considered to provide substantially equivalent benefits if they offer comparable coverage for the following services: hospital room and board, other inpatient hospital services,

surgery, home and office physician services, inhospital physician care, x-ray and laboratory services.

(b) Notwithstanding par. (a), plans providing substantially equivalent benefits may differ as to premium, deductible, coinsurance, benefit maximum provisions and limitations on choice of providers.

(c) Plans providing substantially equivalent benefits may differ in their coverage of services other than those listed in par. (a).

(6) ADEQUATE NOTICE. (a) Preferred provider plans shall provide to policyholders information on the plan, including information on the services covered; a definition of emergency services if emergency services are covered differently than other services; the specific location of providers for each type of service; the cost of the plan; enrollment procedures; limitations on benefits, including limitations or requirements imposed by an institutional provider because of its affiliation with a religious organization; and restrictions on choice of providers. This information shall be provided to employers at least 30 days before the first day of each enrollment period. The preferred provider plans shall ensure that employers make this information available to all prospective certificate holders in time for them to make an informed choice among available plans. If a preferred provider plan is offered on an individual basis, the information shall be given at the time of application.

(b) The information provided shall be legible, complete, understandable, presented in a meaningful sequence, contain a single section listing exclusions and limitations and define words and expressions which are not commonly understood or whose commonly understood meaning is not intended.

(c) The information provided shall meet the standards for an invitation to apply set forth in s. Ins 3.27.

(7) GRIEVANCE PROCEDURE. (a) A preferred provider plan shall investigate each grievance pursuant to s. 609.15 (2), Stats. Each preferred provider plan shall develop an internal grievance procedure and shall describe the grievance procedure in each policy and certificate issued to enrollees. Policies and certificates shall include a definition of a grievance.

(b) In addition to the notice requirement under par. (a), each time the preferred provider plan denies a claim or benefit, including a refusal to refer an enrollee, or initiates disenrollment proceedings, the preferred provider plan shall notify the affected enrollee of the right to file a grievance and the procedure to follow. The notification shall state the specific reason for the denial or initiation.

(c) A preferred provider plan shall resolve all grievances within 30 calendar days of receiving the grievance. If the preferred provider plan is unable to resolve the grievance within 30 calendar days, the time period may be extended an additional 30 calendar days if the preferred provider plan notifies, in writing, the person who filed the grievance that the preferred provider plan has not resolved the grievance, when resolution may be expected, and the reason for why additional time is needed.

(d) A grievance procedure shall include a method whereby the enrollee who made the grievance has the right to appear in person before the grievance committee to present written or oral information and to ques-

tion those people responsible for making the determination which resulted in the grievance. The preferred provider plan shall inform the enrollee in writing of the time and place of the meeting at least 7 calendar days before the meeting.

(e) Pars. (b), (c) and (d) do not apply in urgent care situations. Preferred provider plans shall develop a separate grievance procedure for urgent care situations. This procedure shall require a preferred provider plan to resolve an urgent care situation grievance within 4 business days of receiving the grievance.

(f) Preferred provider plans shall record, retain, and report records for each complaint and grievance in accordance with all of the following requirements:

1. Each preferred provider plan shall keep and retain for at least a three-year period a record for each complaint and grievance submitted to the preferred provider plan.

2. Each provider contract and administrative services agreement entered into between a preferred provider plan and a provider shall contain a provision under which the provider must identify complaints and grievances and forward these complaints and grievances in a timely manner to the preferred provider plan for recording and resolution.

3. Each preferred provider plan shall submit the grievance experience report required by s. 609.15 (1) (c), Stats., to the commissioner by March 1 of each year. The report shall provide information on grievances that were formally reviewed by a grievance panel of the preferred provider plan during the previous calendar year. For purposes of this report, the preferred provider plan shall classify each grievance as follows:

a. Plan administration. A grievance related to plan marketing, policyholder service, billing, underwriting, or similar administrative functions; or

b. Benefits denials. A grievance related to the denial of a benefit, including grievances related to refusals to refer enrollees or provide requested services.

4. Each preferred provider plan shall keep together in a central location of the preferred provider plan all records on complaints and grievances resolved before a formal review by a grievance panel is completed or in which the enrollee does not pursue a resolution. Preferred provider plans shall make these records available for review during examination by or on request of the commissioner.

(g) The commissioner shall by June 1 of each year prepare a report that summarizes grievance experience reports received by the commissioner from preferred provider plans. The report shall also summarize complaints involving preferred provider plans that were received by the office during the previous calendar year.

History: Cr. Register, June, 1984, No. 342, eff. 7-1-84; r. (7) under s. 13.93 (2m) (b) 16, Stats., Register, December, 1984, No. 348; am. (1) and (4) (a), r. (6), Register, September, 1986, No. 369, eff. 10-1-86; renum. (2) to (5) to be (3) to (6), cr. (2) and (7), Register, October, 1989, No. 406, eff. 1-1-90.

**Ins 3.49 Wisconsin automobile insurance plan. (1) PURPOSE.** This section interprets s. 619.01 (6), Stats., to continue a plan to make automobile

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bile 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 [Stats., (1967)] 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) 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 such 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 such insurer. The method shall specify that such requests for review must be made in writing to the Plan and that the decision of the committee in regard to such review may be appealed by the applicant, insured, or company to the commissioner of insurance as provided for in ch. Ins 5. A review or appeal does not operate as a stay of termination.

Note: These requirements reflect former s. 204.51 (2), Stats.

(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.

**Ins 3.50 Health maintenance organizations.** (1) **PURPOSE.** This section establishes financial and other standards for health maintenance organizations doing business in Wisconsin. These requirements are in addition to any other statutory or administrative rule requirements which apply to health maintenance organizations.

(2) **SCOPE.** This section applies to all insurers writing health maintenance organization business in this state.

(3) **DEFINITIONS.** In this section:

(b) "Complaint" means any dissatisfaction about an insurer or its contracted providers expressed by an enrollee.

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(c) "Grievance" means any dissatisfaction with the administration or claims practices of or provision of services by a health maintenance organization which is expressed in writing by or on behalf of a plan enrollee.

(d) "Health maintenance organization" means a health care plan as defined in s. 609.01 (2), Stats.

(e) "Health maintenance organization insurer" has the meaning provided under s. 600.03 (23c), Stats. "Health maintenance organization insurer" does not include a limited service health organization.

(4) FINANCIAL REQUIREMENTS. (a) *Capital*. Unless otherwise ordered by the commissioner the minimum capital or permanent surplus of:

1. A health maintenance organization insurer first licensed or organized on or after July 1, 1989, is \$750,000;

2. A health maintenance organization insurer first licensed or organized prior to July 1, 1989, is \$200,000;

3. Any other insurer writing health maintenance organization business, is the amount of capital or required surplus required under the statutes governing the organization of the insurer.

(b) *Compulsory surplus*. An insurer, including an insurer organized under ch. 613, Stats., writing health maintenance organization business, except for a health maintenance organization insurer, is subject to s. Ins 14.02. A health maintenance organization insurer shall maintain compulsory surplus as follows, or a greater amount required by order of the commissioner:

1. Prior to January 1, 1991, at least the greater of \$500,000 or an amount equal to the sum of:

a. 10% of premium earned in the previous 12 months for policies which include coverages which are other insurance business under s. 609.03 (a) 3, Stats.; plus

b. 3% of all other premium earned in the previous 12 months.

2. In calendar year 1991, at least the greater of \$500,000 or an amount equal to the sum of:

a. 10% of premium earned in the previous 12 months for policies which include coverages which are other insurance business under s. 609.03 (3) (a) 3, Stats.; plus

b. 3% of other premiums earned in the previous 12 months except that if the percentage of the liabilities of the health maintenance organization insurer that are covered liabilities is less than 90%, 4.5% of other premium earned in the previous 12 months.

3. Beginning on January 1, 1992, at least the greater of \$750,000 or an amount equal to the sum of:

a. 10% of premiums earned in the previous 12 months for policies which include coverages which are other insurance business under s. 609.03 (3) (a) 3, Stats.; plus

b. 3% of other premium earned in the previous 12 months except that if the percentage of the liabilities of the health maintenance organization insurer that are covered liabilities is less than 90%, 6% of other premiums earned in the previous 12 months.

(c) *Risks.* Risks and factors the commissioner may consider in determining whether to require greater compulsory surplus by order include, but are not limited to, those described under s. 623.11 (1) (a) and (b), Stats., and the extent to which the insurer effectively transfers risk to providers. A health maintenance organization insurer may transfer risk through any mechanism including, but not limited to, those provided under sub. (5) (d).

(d) *Security surplus.* An insurer, including an insurer organized under ch. 613, Stats., writing health maintenance organization insurance business, except for a health maintenance organization insurer, is subject to s. Ins 14.02. A health maintenance organization insurer should maintain a security surplus to provide an ample margin of safety and clearly assure a sound operation. The security surplus of a health maintenance organization insurer shall be at least the greater of:

1. Compulsory surplus plus 40% reduced by 1% for each \$33 million of premium in excess of \$10 million earned in the previous 12 months; or
2. 110% of its compulsory surplus.

(e) *Insolvency protection for policyholders.* Each health maintenance organization insurer is required to either maintain compulsory surplus as required for other insurers under s. Ins 14.02 or to demonstrate that in the event of insolvency:

1. Enrollees hospitalized on the date of insolvency will be covered until discharged; and
2. Enrollees will be entitled to similar, alternate coverage which does not contain any medical underwriting or pre-existing limitation requirements.

(f) *Setting greater amounts.* The commissioner may set greater amounts under pars. (a) to (d) on finding that the financial stability of the organization requires it.

(h) *Existing insurers.* For health maintenance organizations having a Certificate of Authority on September 29, 1986, this subsection shall become effective on January 1, 1988.

(5) **BUSINESS PLAN.** All applications for certificates of incorporation and certificates of authority of a health maintenance organization insurer shall include a proposed business plan. In addition to the items listed in ss. 611.13 (2) and 613.13 (1), Stats., the following information shall be contained in the business plan:

(a) *Organization type.* The type of health maintenance organization insurer, including whether the providers affiliated with the organization will be salaried employees or group or individual contractors.

(b) *Feasibility studies and marketing surveys.* A summary of feasibility studies or marketing surveys which support the financial and enrollment projections for the health maintenance organization insurer. The summary shall include the potential number of enrollees in the operating ter-



ritory, the projected number of enrollees for the first 5 years, the underwriting standards to be applied, and the method of marketing the organization.

(c) *Geographical service area.* The geographical service area by county including a chart showing the number of primary and specialty care providers with locations and service areas by county; the method of handling emergency care, with locations of emergency care facilities; and the method of handling out-of-area services.

(d) *Provider agreements.* The extent to which any of the following will be included in provider agreements and the form of any provisions which:

1. Limit the providers' ability to seek reimbursement for covered services from policyholders or enrollees;
2. Permit or require the provider to assume a financial risk in the health maintenance organization insurer, including any provisions for assessing the provider, adjusting capitation or fee-for-service rates, or sharing in the earnings or losses; and
3. Govern amending or terminating agreements with providers.

(e) *Provider availability.* A description of how services will be provided to policyholders in each service area including the extent to which primary care will be given by providers under contract to the health maintenance organization insurer.

(f) *Plan administration.* A summary of how administrative services will be provided, including the size and qualifications of the administrative staff and the projected cost of administration in relation to premium income. If management authority for a major corporate function is delegated to a person outside the organization, the business plan shall include a copy of the contract. The contract shall include the services to be provided, the standards of performance for the manager, the method of payment including any provisions for the administrator to participate in the profit or losses of the plan, the duration of the contract and any provisions for modifying, terminating or renewing the contract. Contracts for delegated management authority shall be filed for approval with the commissioner under ss. 611.67 and 618.22, Stats.

(g) *Financial projections.* A summary of current and projected enrollment, income from premiums by type of payor, other income, administrative and other costs, the projected break even point, including the method of funding the accumulated losses until the break even point is reached, and a summary of the assumptions made in developing projected operating results.

(h) *Financial guarantees.* A summary of all financial guarantees by providers, sponsors, affiliates or parents within a holding company system, or any other guarantees which are intended to ensure the financial success of the health maintenance organization insurer. These include hold harmless agreements by providers, insolvency insurance, reinsurance or other guarantees.

(i) *Contracts with enrollees.* A summary of benefits to be offered enrollees including any limitations and exclusions and the renewability of all contracts to be written.

(6) **CHANGES IN THE BUSINESS PLAN.** A health maintenance organization insurer shall file a written report of any proposed substantial change in its business plan. The insurer shall file the report at least 30 days prior to the effective date of the change. The office may disapprove the change. The insurer may not enter into any transaction, contract, amendment to a transaction or contract or take action or make any omission which is a substantial change in the insurer's business plan prior to the effective date of the change or if the change is disapproved. Substantial changes include changes in articles and bylaws, organization type, geographical service areas, provider agreements, provider availability, plan administration, financial projections and guarantees and any other change which might affect the financial solvency of the plan. Any changes in the items listed in sub. (5) (d) shall be filed under this section.

(7) **COPIES OF PROVIDER AGREEMENTS.** All health maintenance organization insurers shall file with the commissioner, prior to doing business, copies of all executed provider agreements and other contracts covering liabilities of the health maintenance organization, except that, for contracts with physicians, a list of physicians executing a standard contract and a copy of the form of the contract may be filed instead of copies of the executed contracts. Executed copies of all provider agreements, including those with physicians, shall be maintained in the insurer's administrative office and shall be made available to the commissioner on request.

(8) **OTHER REPORTING REQUIREMENTS.** (a) All insurers authorized to write health maintenance organization business shall file with the commissioner by March 1 of each year an annual statement for the preceding year. A health maintenance organization insurer shall use the current Health Maintenance Organization annual statement blank prepared by the national association of insurance commissioners. All other insurers shall file an annual report in a form prescribed by the commissioner. A health maintenance organization insurer shall include with its annual statement a statement of covered expenses, and a special procedures opinion from a certified public accountant, in the form prescribed by the commissioner as Appendix B.

(b) A health maintenance organization insurer shall file a quarterly report, including a report concerning covered expenses, in a form prescribed by the commissioner, within 45 days after the close of each of the first 3 quarters of the year unless the commissioner has notified the insurer that another reporting schedule is appropriate.

(c) A health maintenance organization insurer shall include with its annual audit financial reports filed under s. Ins 16.02 a statement of covered expenses and an audit opinion concerning the statement. Both the statement and opinion shall be in the form prescribed by the commissioner as Appendix C.

(d) An insurer writing health maintenance organization business, other than a health maintenance organization insurer, shall file a quarterly report in a form prescribed by the commissioner within 45 days after the close of each of the first 3 quarters of the year unless the commissioner notifies the insurer that another reporting schedule is appropriate.

(e) 1. If a health maintenance organization insurer fails to file a statement or opinion required under pars. (a) to (c) by the time required, it is presumed, in any action brought by the office within one year of the due

date, that the health maintenance organization insurer is in financially hazardous condition and that the percentage of its liabilities for health care costs which are covered liabilities is and continues to be less than 65% for the purpose of s. 609.95, Stats.

2. It is presumed that the percentage of liabilities which are covered liabilities of a health maintenance organization insurer is and continues to be not greater than the percentage of covered expenses stated in the report or statement filed under pars. (a) to (d) for the most recent period.

3. The health maintenance organization insurer has the burden of refuting a presumption under subd. 1 or 2.

(8g) **TERMINATION OF HOLD HARMLESS.** (a) Notice of election to be exempt from s. 609.91 (1) (b), Stats., or notice of termination of election to be subject to s. 609.91 (1) (c), Stats., is effective only if filed on the form prescribed by the commissioner and if the form is properly completed.

(b) A health care provider shall use the form prescribed by the commissioner for filing notice of termination of election to be exempt under s. 609.91 (1) (b), Stats., or notice of termination of election to be subject to s. 609.91 (1) (c), Stats. A filing which is not on the prescribed form is not effective. If a provider fails to use or to properly complete the form prescribed for notice of termination of election to be exempt from s. 609.91 (1) (b), Stats., or notice of election to be subject to s. 609.91 (1) (c), Stats., the filing is nevertheless effective.

(8m) **RECEIVABLES FROM AFFILIATES.** A receivable, note or other obligation of an affiliate to a health maintenance organization insurer shall be valued at zero by the insurer for all purposes including, but not limited to, for the purpose of reports or statements filed with the office, unless the commissioner specifically approves a different value. The different value shall be not more than the amount of the receivable, note or other obligation which is fully secured by a security interest in cash or cash equivalents held in a segregated account or trust.

(8s) **RECEIVABLES FROM IPA.** After December 31, 1990, a health maintenance organization insurer shall value receivables, notes or obligations of individual practice associations as defined under s. 600.03 (23g), Stats., at zero for all purposes including, but not limited to, for the purpose of reports or statements filed with the office, unless the receivable, note or obligation is fully secured by a security interest in cash or cash equivalents held in a segregated account or trust.

(8u) **INCIDENTAL OR IMMATERIAL INDEMNITY BUSINESS IN HEALTH MAINTENANCE ORGANIZATIONS.** (a) Except as provided by par. (b), insurance business is not incidental or immaterial under s. 609.03 (3) (a) 3, Stats., if a health maintenance organization insurer issues coverage which is not typically included in a health maintenance organization or limited service health organization policy and the insurer either:

1. Markets the policy containing the coverage; or

2. The total premium for policies containing the coverage exceeds or is projected to exceed 5% of total premium earned in any 12-month period.

(b) Insurance business is incidental or immaterial under s. 609.03 (3) (a) 3, Stats., if the business is written according to the terms of a specific business plan for issuance of coverage under s. 609.03 (3) (a) 3, Stats.,

and the business plan is approved in writing by the office. A request for approval to do business under this paragraph including, but not limited to, issuance of policies with point of service coverage, shall include a detailed business plan, a copy of the policy form, a detailed description of how the business will be marketed and premium volume controlled, and other information prescribed by the office. The total premium for policies containing coverages subject to this paragraph and policies issued under par. (a) may not exceed 10% of premium earned or projected to be earned in any 12-month period.

(c) If the commissioner approves insurance business as incidental or immaterial the commissioner may also, by order under sub. (4) (b), require the insurer to maintain more than the minimum compulsory surplus.

(d) For the purpose of this section any coverage which covers services by a provider other than a selected provider is not typically included in a health maintenance organization or limited service health organization policy, except coverage of emergency out-of-area services.

(8x) SUMMARY. A health maintenance organization insurer shall use the form prescribed in Appendix A to comply with s. 609.94, Stats.

(8z) NONDOMESTIC HMO. No certificate of authority may be issued under ch. 618, Stats., on or after September 1, 1990, to a person to do health maintenance organization or limited service health organization business in this state unless the person is organized and regulated as an insurer and domiciled in the United States. Any person issued a certificate of authority under ch. 618, Stats., to do health maintenance organization business prior to the effective date of this rule which is not organized and regulated as an insurer and domiciled in the United States shall cease doing business in this state not later than January 1, 1993.

(9) POLICY AND CERTIFICATE LANGUAGE REQUIREMENTS. Each policy form marketed by a health maintenance organization and each certificate given to enrollees shall contain:

(a) A definition of geographical service area, emergency care, urgent care, out-of-area services, dependents and primary provider, if these terms or terms of similar meaning are used in the policy or certificate and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the policy or certificate if such definition is adequately described in an attachment which is given to all enrollees along with the policy or certificate.

(b) Clear disclosure of any provision which limits benefits or access to service in the exclusions, limitations, and exceptions sections of the policy or certificate. Among the exclusions, limitations and exceptions which shall be disclosed are those relating to emergency and urgent care, restrictions on the selection of primary or referral providers, restrictions on changing providers during the contract period, out-of-pocket costs including copayments and deductibles, charges for missed appointments or other administrative sanctions, restrictions on access to care if copayments or other charges are not paid, and any restrictions on coverage for dependents who do not reside in the service area.

(c) Clear disclosure of any benefits for home health care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for de-

pendent children, alcoholism and other drug abuse, and nervous and mental disorders.

(10) GRIEVANCE PROCEDURE. (a) A health maintenance organization shall investigate each grievance pursuant to s. 609.15 (2), Stats. Each health maintenance organization shall develop an internal grievance procedure which shall be described in each policy and certificate issued to enrollees. Policies and certificates shall include a definition of a grievance.

(b) In addition to the notice requirement under par. (a), each time the health maintenance organization denies a claim or benefit, including a refusal to refer an enrollee, or initiates disenrollment proceedings, the health maintenance organization shall notify the affected enrollee of the right to file a grievance and the procedure to follow. The notification shall state the specific reason for the denial or initiation.

(c) The health maintenance organization shall resolve all grievances within 30 calendar days of receiving the grievance. If the health maintenance organization is unable to resolve the grievance within 30 calendar days, the time period may be extended an additional 30 calendar days if the health maintenance organization notifies, in writing, the person who filed the grievance that the health maintenance organization has not resolved the grievance, when resolution may be expected, and the reason for why additional time is needed.

(d) A grievance procedure shall include a method whereby the enrollee who made the grievance has the right to appear in person before the grievance committee to present written or oral information and to question those people responsible for making the determination which resulted in the grievance. The health maintenance organization shall inform the enrollee in writing of the time and place of the meeting at least 7 calendar days before the meeting.

(e) Pars. (b), (c) and (d) do not apply in urgent care situations. Health maintenance organizations shall develop a separate grievance procedure for urgent care situations. This procedure shall require a health maintenance organization to resolve an urgent care situation grievance within 4 business days of receiving the grievance.

(f) The health maintenance organization shall acknowledge a grievance within 10 days of receiving it.

(g) Health maintenance organizations shall record, retain, and report records for each complaint and grievance in accordance with all of the following requirements:

1. Each health maintenance organization shall keep and retain for at least a three-year period a record for each complaint and grievance submitted to the health maintenance organization.

2. Each provider contract and administrative services agreement entered into between a health maintenance organization and a provider shall contain a provision under which the provider must identify complaints and grievances in a timely manner and forward these complaints and grievances in a timely manner to the health maintenance organization for recording and resolution.

3. Each health maintenance organization shall submit a grievance experience report required by s 609.15 (1) (c), Stats., to the commissioner by March 1 of each year. The report shall provide information on grievances received during the previous calendar year that were formally reviewed by a grievance panel of the health maintenance organization. For purposes of this report, the health maintenance organization shall classify each grievance as follows:

a. Plan administration. A grievance related to plan marketing, policyholder service, billing, underwriting, or similar administrative functions; or

b. Benefits denials. A grievance related to the denial of a benefit, including grievances related to refusals to refer enrollees or provide requested services.

4. Each health maintenance organization shall keep together in a central location of the health maintenance organization all records on complaints and grievances resolved before a formal review by a grievance panel is completed or in which the enrollee does not pursue a resolution. The health maintenance organization shall make these records available for review during examinations by or on request of the commissioner.

(h) The commissioner shall by June 1 of each year prepare a report that summarizes grievance experience reports received by the commissioner from health maintenance organizations. The report shall also summarize complaints involving health maintenance organizations that were received by the office during the previous calendar year.

(11) OTHER NOTICE REQUIREMENTS. (a) Prior to enrolling members, the health maintenance organization shall provide to prospective group or individual policyholders information on the plan, including information on the services covered, a definition of emergency and out-of-area coverage, names and specific location of providers for each type of service, the cost of the plan, enrollment procedures, and limitations on benefits including limitations on choice of providers and the geographical area serviced by the organization.

(b) If a health maintenance organization terminates its relationship with any clinic or medical group it shall notify all subscribers who receive primary health care services from that clinic or medical group at least 30 days in advance of such termination. The health maintenance organization shall notify all subscribers in a geographical area served by the plan of any changes in its affiliations with providers which have a substantial effect on the availability of covered services in the area.

(12) DISENROLLMENT. (a) The health maintenance organization shall clearly disclose in the policy and certificate any circumstances under which the health maintenance organization may disenroll an enrollee.

(b) Except as provided in s. 632.897, Stats., the health maintenance organization may disenroll an enrollee from the health maintenance organization for the following reasons only:

1. The enrollee has failed to pay required premiums by the end of the grace period.

2. The enrollee has committed acts of physical or verbal abuse which pose a threat to providers or other members of the organization.

3. The enrollee has allowed a nonmember to use the health maintenance organization's certification card to obtain services or has knowingly provided fraudulent information in applying for coverage.

4. The enrollee has moved outside of the geographical service area of the organization.

5. The enrollee is unable to establish or maintain a satisfactory physician-patient relationship with the physician responsible for the enrollee's care. Disenrollment of an enrollee for this reason shall be permitted only if the health maintenance organization can demonstrate that it provided the enrollee with the opportunity to select an alternate primary care physician, made a reasonable effort to assist the enrollee in establishing a satisfactory patient-physician relationship and informed the enrollee that he or she may file a grievance on this matter.

(c) The health maintenance organization may not disenroll an enrollee under par. (b) for reasons related to the physical or mental condition of the enrollee or for any of the following reasons:

1. Failure of the enrollee to follow a prescribed course of treatment.
2. Administrative actions such as failure to keep an appointment.

(d) A health maintenance organization which has disenrolled an enrollee for any reason except failure to pay required premiums shall make arrangements to provide similar alternate insurance coverage to enrollees. In the case of group certificate holders, this insurance coverage shall be continued until the person finds his or her own coverage or until the next opportunity to change insurers, whichever comes first. In the case of an enrollee covered on an individual basis, coverage shall be continued until the anniversary date of the policy or for one year, whichever is earlier.

(13) TIME PERIOD. In accordance with s. 227.116, Stats., the commissioner shall review and make a determination on an application for a certificate of authority within 60 business days after it has been received.

History: Cr. Register, June, 1986, No. 366, eff. 9-29-86; renum. (3) (b) and (10) (c) to be (3) (d) and (10) (f), r. (10) (d), cr. (3) (b) and (c), (10) (c) to (e), (g) and (h), am. (10) (a) and (b), Register, October, 1989, No. 406, eff. 1-1-90; r. and recr. (2) and (4) (a) to (c), r. (3) (a) and (4) (e), renum. (4) (f) and (g) to be (4) (e) and (f) and am. (4) (e) (intro.) and (4) (f), cr. (3) (intro.) and (e), (8) (c) to (e), (8g), (8s), (8u), (8x) and (8z), am. (4) (d) (intro.), (5) (intro.) to (b), (d) 2., (e) and (h) and (6) to (8), Register, August, 1990, No. 416, eff. 9-1-90.

Ins 3.50 Appendix A

NOTICE

**THIS NOTICE DESCRIBES HOLD-HARMLESS PROVISIONS  
WHICH AFFECT YOUR ABILITY TO SEEK RECOURSE AGAINST  
HMO ENROLLEES FOR PAYMENT FOR SERVICES**

Section 609.94, Wis. Stat., requires each health maintenance organization insurer (HMO) to provide a summary notice to all of its participating providers of the statutory limitations and requirements in §§ 609.91 to 609.935, and § 609.97 (1), Wis. Stat.

SUMMARY

Under Wisconsin law a health care provider may not hold HMO enrollees or policyholders ("enrollees") liable for costs covered under an HMO policy if the provider is subject to statutory provisions which "hold harmless" the enrollees. For most health care providers application of the statutory hold-harmless is "mandatory" or it applies unless the provider elects to "opt-out." A provider permitted to "opt-out" must file timely notice with the Wisconsin Office of the Commissioner of Insurance ("OCI").

Some types of provider care are subject to the statutes only if the provider voluntarily "opts-in." An HMO may partially satisfy its regulatory capital and surplus requirements if health care providers elect to remain subject to the statutory hold-harmless provisions.

This notice is only a summary of the law. Every effort has been made to accurately describe the law. However, if this summary is inconsistent with a provision of the law or incomplete, the law will control.

Filings for exemption with OCI must be on the prescribed form to be effective.

**HOLD HARMLESS**

A health care provider who is subject to the statutory hold-harmless provisions is prohibited from seeking to recover health care costs from an enrollee. The provider may not bill, charge, collect a deposit from, seek remuneration or compensation from, file or threaten to file with a credit reporting agency or 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 effect the liability of an enrollee for any deductibles or copayments, or for premiums owed under the policy or certificate issued by the HMO.

**A. MANDATORY FOR HOLD HARMLESS**

An enrollee of an HMO is not liable to a health care provider for health care costs which are covered under a policy issued by that HMO if:

1. Care is provided by a provider who is an affiliate of the HMO, owns at least 5% of the voting securities of the HMO, is directly or indirectly involved with the HMO through direct or indirect selection of or representation by one or more board members, or is an Individual



Practice Association ("IPA") and is represented, or an affiliate is represented, by one of at least three HMO board members who directly or indirectly represent one or more Independent Practice Associations ("IPAs") or affiliates of IPAs; or,

2. Care is provided by a provider under a contract with or through membership in an organization identified in 1.; or
3. To the extent the charge exceeds the amount the HMO has contractually agreed to pay the provider for that health care service; or
4. The care is provided to an enrolled medical assistance recipient under a Department of Health and Social Services prepaid health care policy.

**B. "OPT-OUT" HOLD HARMLESS**

If the conditions described in A do not apply, the provider will be subject to the statutory hold harmless unless the provider files timely election with OCI to be exempt if the health care is:

1. Provided by a hospital or an IPA; or
2. A physician service, or other provider services, equipment, supplies or drugs that are ancillary or incidental to such services and are provided under a contract with the HMO or are provided by a provider selected by the HMO; or
3. Provided by a provider, other than a hospital, under a contract with or through membership in an IPA which has not elected to be exempt. Note that only the IPA may file election to exempt care provided by its member providers from the statutory hold harmless. (See Exemptions and Elections, No. 4.)

**C. "OPT-IN" HOLD HARMLESS**

If a provider of health care is not subject to the conditions described in A or B, the provider may elect to be subject to the statutory hold-harmless provisions by filing a notification with OCI stating that the provider elects to be subject with respect to any specific HMO. A provider may terminate such a notice of election by stating the termination date in that notice or in a separate notification.

**CONDITIONS NOT AFFECTING IMMUNITY**

An enrollee's immunity under the statutory hold harmless is not affected by any of the following:

1. Any agreement entered into by a provider, an HMO, or any other person, whether oral or written, purporting to hold the enrollee liable for costs (except a notice of election or termination permitted under the statute;
2. A breach of or default on any agreement by the HMO, an IPA, or any other person to compensate the provider for health care costs for which the enrollee is not liable.
3. The insolvency of the HMO or any person contracting with the HMO, or the commencement of insolvency, delinquency or bankruptcy proceedings involving the HMO or other persons which

would affect compensation for health care costs for which an enrollee is not liable under the statutory hold harmless;

4. The inability of the provider or other person who is owed compensation to obtain compensation for health care costs for which the enrollee is not liable;
5. Failure by the HMO to provide notice to providers of the statutory hold-harmless provisions; or
6. Any other conditions or agreement existing at any time.

#### EXEMPTIONS AND ELECTIONS

Hospital, IPAs, and providers of physician services who may "opt-out" may elect to be exempt from the statutory hold harmless and prohibition on recovery of health care costs under the following conditions and with the following notifications:

1. If the hospital, IPA, or other provider has a written contract with the HMO, the provider must within thirty (30) days after entering into that contract provide a notice to the OCI of the provider's election to be exempt from the statutory hold-harmless and recovery limitations for care under the contract.
2. If the hospital, IPA, or other provider does not have a contract with an HMO, the provider must notify OCI that it intends to be exempt with respect to a specific HMO and must provide that notice for the period January 1, 1990, to December 31, 1990, at least sixty (60) days before the health care costs are incurred; and must provide that notice for health care costs incurred on and after January 1, 1991, at least 90 days in advance.
3. A provider who submits a notice of election to be exempt may terminate that election by stating a termination date in the notice or by submitting a separate termination notice to OCI.
4. The election by an IPA to be exempt from the statutory provisions, or the failure of an IPA to so elect, applies to costs of health care provided by any provider, other than a hospital, under contract with or through membership in the IPA. Such a provider, other than a hospital, may not exercise an election separately from the IPA. Similarly, an election by a clinic to be exempt from the statutory limitations and restrictions or the failure of the clinic to elect to be exempt applies to costs of health care provided by any provider through the clinic. An individual provider may not exercise an election to be exempt separate from the clinic.
5. The statutory hold-harmless "opt-out" provision applies to physician services only if the services are provided under a contract with the HMO or if the physician is a selected provider for the HMO, unless the services are provided by a physician for a hospital, IPA or clinic which is subject to the statutory hold-harmless "opt-out" provision.

#### NOTICES

All notices of election and termination must be in writing and in accordance with rules promulgated by the Commissioner of Insurance. All Register, August, 1990, No. 416

notices of election or termination filed with OCI are not affected by the renaming, reorganization, merger, consolidation or change in control of the provider, HMO, or other person. However, OCI may promulgate rules requiring an informational filing if any of these events occur.

Notices to the Office of the Commissioner of Insurance must be written, on the prescribed form, and received at the Office's current address:

P.O. Box 7873, Madison, WI 53707-7873

### HMO CAPITAL AND SECURITY SURPLUS

Each HMO is required to meet minimum capital and surplus standards ("compulsory surplus requirements"). These standards are higher if the HMO has fewer than 90% of its liabilities covered by the statutory hold-harmless. Specifically, the compulsory surplus requirements are as follows:

1. From January 1, 1990, through December 31, 1990, at least the greater of \$500,000 or 3% of the premiums earned by the HMO in the previous 12 months.
2. From January 1, 1991, through December 31, 1991, at least the greater of \$500,000 or 4.5% of the premiums earned by the HMO in the previous 12 months if its covered liabilities are less than 90%, or 3% of the premiums earned by the HMO in the last 12 months if its covered liabilities are 90% or more.
3. Beginning January 1, 1992, at least the greater of \$750,000 or 6% of the premiums earned by the HMO in the last 12 months if its covered liabilities are less than 90%, or 3% of the premiums earned by the HMO in the last 12 months if its covered liabilities are 90% or more.

In addition to capital and surplus, an HMO must also maintain a security surplus in the amount set by the Commissioner of Insurance.

### FINANCIAL INFORMATION

An HMO is required to file financial statements with OCI. You may request financial statements from the HMO. OCI also maintains files of HMO financial statements which can be inspected by the public.

Ins 3.50 Appendix B

AUDITOR'S SPECIAL PROCEDURES REPORT ON THE  
SCHEDULE OF COVERED EXPENSES

Board of Directors  
XYZ HMO

We have performed the following special procedures with respect to the Schedule of Covered Expenses for XYZ HMO for the year ended December 31, XXXX. It is understood that this report is solely to assist you in complying with s. Ins 3.50, Wis. Adm. Code, and ch. 609, Wis. Stats., and our report is not be used for any other purpose. Our procedures and findings are as follows:

- a. A randomly selected sample was taken from all medical and hospital expenses paid during the calendar year to test the attribute that the expenses reported on the provider's IRS 1099-MISC forms (or other supporting documentation for providers not issued an IRS-1099-MISC form) trace to the Schedule of Covered Expenses for those providers included on the Schedule of Covered Expenses.
- b. A comparison was made between the Schedule of Covered Expenses and the Election of Exemption notices by providers to verify that providers which had given notice of their Election of Exemption prior to December 31, XXXX, and which had not also given notice of their Termination of Election prior to December 31, XXXX, are excluded from the Schedule of Covered Expenses.
- c. A review of the assumptions and methods of the HMO in establishing the amount of covered expenses included in the Incurred But Not Reported line of the Schedule of Covered Expenses was undertaken to determine if the company's estimate is reasonably estimated based on the HMO's historical data and best information available to the HMO.

Because the procedures do not constitute an examination made in accordance with generally accepted auditing standards, we do not express an opinion on any of the accounts or items referred to above. The following summarizes our findings as a result of the procedures referred to above.

FINDINGS REPORTED HERE

Had we performed any additional procedures, other matters might have come to our attention that would have been reported to you. This report relates only to the items specified above and does not extend to any financial statements of the HMO taken as a whole.

Date

CPA Signature

## Ins. 3.50 Appendix C

AUDITOR'S REPORT ON THE SCHEDULE OF COVERED  
EXPENSES

Date

BOARD OF DIRECTORS  
XYZ Health Maintenance Organization

We have audited, in accordance with generally accepted auditing standards, Financial Statements of XYZ Health Maintenance Organization for the year ended December 31, XXXX, and have issued our report thereon dated XXXXXXXXXXXX XX, XXXX. We have also audited the accompanying Schedule of Covered Expenses for XYZ Health Maintenance Organization as of December 31, XXXX. This schedule is the responsibility of management of XYZ Health Maintenance Organization. Our responsibility is to express an opinion on this schedule based on our audit.

We conducted our audit in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the aforementioned schedule is free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the aforementioned schedule. An audit also includes assessing the accounting principles used and any significant estimates made by management, as well as evaluating the overall schedule presentations. We believe that our audit provides reasonable basis for our opinion.

In our opinion, the schedule referred to above presents fairly, in all material respects, covered expenses for the year ended December 31, XXXX.

CPA Signature

**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.

**Ins 3.52 Limited service health organizations.** (1) **PURPOSE.** This section establishes financial and other standards for limited services health organizations doing business in Wisconsin. The requirements in this section are in addition to any other statutory or administrative rule requirements which apply to limited service health organizations.

(2) **SCOPE.** Except for subs. (4) and (8), this section applies to all limited service health organizations doing business in Wisconsin. Subsections (4) and (8) do not apply to a limited service health organization operated as a line of business of a licensed insurer unless the insurer does substantially all of its business as a limited service health organization.

(3) **DEFINITIONS.** (a) "Acceptable letter of credit" means a clean, unconditional, irrevocable letter of credit issued by a Wisconsin bank or any other financial institution acceptable to the commissioner which renews on an annual basis for a 3-year term unless written notice of nonrenewal is given to the commissioner and the limited service health organization at least 60 days prior to the renewal date.

(b) "Complaint" means any dissatisfaction about an insurer or its contracted providers expressed by an enrollee.

(c) "Grievance" means any dissatisfaction with the administration or claims practices of or provision of services by a limited service health organization which is expressed in writing by or on behalf of a plan enrollee.

(a) "Limited service health organization" means a health care plan as defined in s. 609.01 (3), Stats.

(4) **FINANCIAL REQUIREMENTS.** (a) *Minimum capital or permanent surplus.* The minimum capital or permanent surplus requirement for a limited service health organization shall be not less than \$75,000.

(b) *Security deposit.* 1. Each limited service health organization shall maintain either a deposit of securities with the state treasurer or an acceptable letter of credit on file with the commissioner's office. The amount of the deposit or letter of credit shall be not less than \$75,000 for limited service health organizations. The letter of credit shall be payable to the commissioner whenever rehabilitation or liquidation proceedings are initiated against the limited service health organization.

2. The commissioner may accept the deposit or letter of credit under subd. 1. to satisfy the minimum capital or permanent surplus requirement under par. (a), if the limited service health organization demonstrates to the satisfaction of the commissioner that it does not retain any risk of financial loss because all risk of loss has been transferred to providers through provider agreements.

(c) *Compulsory surplus.* 1. Each limited service health organization shall maintain a compulsory surplus to provide security against contingencies that affect its financial position but which are not fully covered by provider contracts, insolvency insurance, reinsurance, or other forms of financial guarantees. The compulsory surplus is equal to not less than the greater of:

a. 3% of the premiums earned by the limited service health organization in the previous 12 months; or

b. \$75,000.

2. The commissioner may accept the deposit or letter of credit under par. (b) to satisfy the compulsory surplus requirement if the limited service health organization demonstrates to the satisfaction of the commissioner that it does not retain any risk of financial loss because all risk of loss has been transferred to providers through provider agreements. The commissioner may, by order, require a higher or lower compulsory surplus or may establish additional factors for determining the amount of compulsory surplus required for a particular limited service health organization.

(d) *Security surplus.* The limited service health organization should maintain a security surplus to provide an ample margin of safety and clearly assure a sound operation. The security surplus of a limited service health organization shall be equal to not less than 110% of compulsory surplus.

(e) *Operating funds.* The limited service health organization shall make arrangements, satisfactory to the commissioner, to provide sufficient funds to finance any operating deficits in the business and to prevent impairment of the insurer's initial capital or permanent surplus or its compulsory surplus. To determine the acceptability of these arrangements the commissioner shall take into account reasonable projections of enrollments, claims and administrative costs, financial guarantees given to the organization, the financial condition of any guarantors and other relevant information.

(f) *Setting greater amounts.* The commissioner may require, based on the actual operating experience of a particular insurer, greater amounts



under pars. (a), (d) and (e) on finding that the financial stability of the organization requires it. Higher financial standards may be applied to a limited service health organization which does not transfer all of the risk to individual providers.

(g) *Insolvency protection for policyholders.* Each limited service health organization which provides hospital benefits shall demonstrate that, in the event of an insolvency, enrollees hospitalized at the time of an insolvency will be covered until discharged.

(5) **BUSINESS PLAN.** All applications for certificates of incorporation and certificates of authority of a limited service health organization shall include a proposed business plan. Limited service health organizations that are not separately licensed shall submit a proposed business plan prior to doing business as a limited service health organization unless the commissioner waives this requirement. In addition to the items listed in ss. 611.13 (2) and 613.13 (1), Stats., the business plan shall contain the following information:

(a) *Identity of organization.* The name and address of the limited service health organization and the names and addresses of individual providers, if any, who control the limited service health organization.

(b) *Organization type.* The type of organization, including information on whether providers will be salaried employes of the organization or individual or group contractors.

(c) *Feasibility study.* A feasibility study which supports the financial and enrollment projections of the plan, including the potential number of enrollees in the geographical service area, the estimated number of enrollees for the first 5 years, the underwriting standards to be applied, and the method of marketing the organization.

(d) *Geographical service area.* The geographical service area by county including a chart showing the number of primary and specialty care providers with locations and service areas by county; the method of handling emergency care, with locations of emergency care facilities; and the method of handling out-of-area services.

(e) *Provider agreements.* The extent to which any of the following are or are not included in provider agreements and the form of any provisions which:

1. Limit the providers' ability to seek reimbursement for covered services from policyholders or enrollees;

2. Permit or require the provider to assume a financial risk in the limited services health organization, including any provisions for assessing the provider, adjusting capitation or fee-for-service rates, or sharing in the earnings or losses of the organization; or

3. Govern amending or terminating the agreement or the effect of amending or terminating the agreement.

(f) *Plan administration.* 1. A copy of the administrative agency contract if management or administrative authority for the operation of the limited service health organization is delegated to a person or organization outside of the limited service health organization. This administration contract shall include a description of the services to be provided, the standards of performance for the administrative agent, the method

of payment, including any provisions for the administrative agent to participate in profit or losses in the plan, the duration of the contract and any provisions for modifying, terminating, or renewing the contract.

2. A summary of how the limited service health organization will provide administrative services, including size and qualifications of the administrative staff, and the projected cost of administration in relation to premium income shall accompany the application if a limited service health organization provides its own administrative services and does not delegate these functions to a person or organization outside of the limited service health organization.

(g) *Financial projections.* A summary of current and projected enrollment, income from premiums by type of payor, other income, administrative and other costs, the projected break even point, including the method of funding the accumulated losses until the income and expense reach the break even point, and a summary of the assumptions made in developing projected operating results.

(h) *Financial guarantees.* A summary of all financial guarantees by providers, sponsors, affiliates or parents within a holding company system, or any other guarantees which are intended to ensure the financial success of the plan. Such guarantees include, but are not limited to, hold harmless agreements by providers, insolvency insurance, reinsurance or other guarantees.

(i) *Contracts with enrollees.* A summary of benefits to be offered enrollees including any limitations and exclusions and the renewability of all contracts to be written.

(6) **CHANGES IN THE BUSINESS PLAN.** All substantial changes, alterations or amendments to the business plan shall be filed with the commissioner at least 30 days prior to their effective date and shall be subject to disapproval by the commissioner. These include changes to articles and bylaws, organization type, geographical service area, provider agreements, provider availability, plan administration, financial projections and guarantees and any other change which might affect the financial solvency of the plan. Any changes in the items listed in sub. (5) (e) shall be filed under this section.

(7) **PROVIDER AGREEMENTS.** (a) Prior to doing business, all limited service health organizations shall file with the commissioner copies of all executed provider agreements and other contracts covering its liabilities except that a limited service health organization may file a list of providers executing a standard contract and a copy of the form of the contract instead of copies of the individual executed contracts.

(b) A limited service health organization shall maintain executed copies of all provider agreements in its administrative office and shall make the copies available to the commissioner on request.

(8) **OTHER REPORTING REQUIREMENTS.** (a) A limited service health organization shall file an annual statement for the preceding year with the commissioner by March 1 of each year and shall put the statement on the current health maintenance organization annual statement blank prepared by the national association of insurance commissioners.

(b) The commissioner may require other reports on a regular or other basis as appropriate.

(9) **POLICY AND CERTIFICATE LANGUAGE REQUIREMENTS.** Each policy form marketed by a limited service health organization and each certificate given to enrollees shall contain:

(a) A definition of geographical service area, emergency care, urgent care, out-of-area services, dependents and primary provider, if these terms or terms of similar meaning are used in the policy or certificate and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the policy or certificate if the definition is adequately described in an attachment which is given to all enrollees along with the policy or certificate.

(b) Clear disclosure in the exclusions, limitations, and exceptions section of any provision which limits benefits or access to service. The exclusions, limitations and exceptions which shall be disclosed include those relating to emergency and urgent care, restrictions on the selection of primary or referral providers, restrictions on changing providers during the contract period, out-of-pocket costs including copayments and deductibles, charges for missed appointments or other administrative sanctions, restrictions on access to care if copayments or other charges are not paid, and any restrictions on coverage for dependents who do not reside in the service area.

(10) **GRIEVANCE PROCEDURE.** (a) A limited service health organization shall investigate each grievance pursuant to s. 609.15 (2), Stats. Each limited service health organization shall develop an internal grievance procedure which shall be described in each policy and certificate issued to enrollees. Policies and certificates shall include a definition of a grievance.

(b) In addition to the notice requirement in par. (a), each time the limited service health organization denies a claim or benefit, including a refusal to refer an enrollee, and each time it initiates disenrollment proceedings under sub. (12) (b) 5, the limited service health organization shall notify the affected enrollee of the right to file a grievance and the procedure to follow. The notification shall state the specific reason for the denial or initiation.

(c) A limited service health organization shall resolve all grievances within 30 calendar days of receiving the grievance. If the limited service health organization is unable to resolve the grievance within 30 calendar days, the time period may be extended an additional 30 calendar days if the limited service health organization notifies, in writing, the person who filed the grievance that the limited service health organization has not resolved the grievance, when resolution may be expected, and the reason for why additional time is needed.

(d) A grievance procedure shall include a method whereby the enrollee who made the grievance has the right to appear in person before the grievance committee to present written or oral information and to question those people responsible for making the determination which resulted in the grievance. The limited service health organization shall inform the enrollee in writing of the time and place of the meeting at least 7 calendar days before the meeting.

(e) Pars. (b), (c) and (d) do not apply in urgent care situations. Limited service health organizations shall develop a separate grievance procedure for urgent care situations. This procedure shall require a limited

service health organization to resolve an urgent care situation grievance within 4 business days of receiving the grievance.

(f) The limited service health organization shall acknowledge a grievance within 10 days of receiving it.

(g) Limited service health organizations shall record, retain, and report records for each complaint and grievance with all of the following requirements:

1. Each limited service health organization shall keep and retain for at least a three-year period a record for each complaint and grievance submitted to the limited service health organization.

2. Each provider contract and administrative services agreement entered into between a limited service health organization and a provider shall contain a provision under which the provider must identify complaints and grievances and forward these complaints and grievances in a timely manner to the limited service health organization for recording and resolution.

3. Each limited service health organization shall submit a grievance experience report required by s. 609.15 (1) (c), Stats., to the commissioner by March 1 of each year. The report shall provide information on grievances received during the previous calendar year that were formally reviewed by a grievance panel of the limited service health organization. For purposes of this report, the limited service health organization shall classify each grievance as follows:

a. Plan administration. A grievance related to plan marketing, policyholder service, billing, underwriting, or similar administrative functions; or

b. Benefit denials. A grievance related to the denial of a benefit, including grievances related to refusals to refer enrollees or provide requested services.

4. Each limited service health organization shall keep together in a central location of the limited service health organization all records on complaints and grievances resolved before a formal review by a grievance panel is completed or in which the enrollee does not pursue a resolution. The limited service health organization shall make these records available for review during examinations by or on request of the commissioner.

(h) The commissioner shall by June 1 of each year prepare a report that summarizes grievance experience reports received by the commissioner from limited service health organizations. The report shall also summarize complaints involving limited service health organizations that were received by the office during the previous calendar year.

(11) OTHER NOTICE REQUIREMENTS. Prior to enrolling members, the limited service health organization shall provide to all prospective group or individual policyholders information on the plan, including information on the services covered, a definition of emergency and out-of-area coverage, names and specific location of providers for each type of service, the cost of the plan, enrollment procedures, and limitations on benefits including limitations on choice of providers and the geographical area served by the organization.

(12) **DISENROLLMENT.** (a) The limited service health organization shall clearly disclose in the policy and certificate any circumstances under which the limited service health organization may disenroll an enrollee.

(b) The limited service health organization may disenroll a member from the limited service health organization for the following reasons only:

1. The policyholder has failed to pay required premiums by the end of the grace period.

2. The enrollee has committed acts of physical or verbal abuse which pose a threat to providers or other members of the organization.

3. The enrollee has allowed a nonmember to use the limited service health organization's membership card or has knowingly provided fraudulent information in applying for coverage with the limited service health organization or in receiving services.

4. The enrollee has moved outside of the geographical service area of the organization.

5. The enrollee is unable to establish or maintain a satisfactory provider-patient relationship with the provider responsible for the enrollee's care. Disenrollment of an enrollee for this reason shall be permitted only if the limited service health organization can demonstrate that it provided the enrollee with the opportunity to select an alternate primary care provider, made a reasonable effort to assist the enrollee in establishing a satisfactory provider-patient relationship and informed the enrollee that he or she may file a grievance on this matter.

(c) A limited service health organization that has disenrolled an enrollee for any reason except failure to pay required premiums shall make arrangements to provide similar insurance coverage to the enrollee. In the case of group certificate holders this insurance coverage shall be continued until the person is able to find similar coverage or until the next opportunity to change insurers, whichever comes first. In the case of an enrollee covered on an individual basis, coverage shall be continued until the anniversary date of the policy or for one year, whichever is earlier.

(13) **TIME PERIOD FOR REVIEW.** In accordance with s. 227.116, Stats., the commissioner shall review and make a determination on an application for a certificate of authority within 60 business days after it has been received.

(14) Subs. (9), (10), (11) and (12) shall apply to all policies issued or renewed on or after January 1, 1987.

Note: Section Ins 3.51 shall not apply to policies issued or renewed before January 1, 1987.

History: Cr. Register, November, 1986, No. 371, eff. 12-1-86; renum. (3) (b) and (10) (c) to be (3) (d) and (10) (f), r. (10) (d), cr. (3) (b) and (c), (10) (c) to (e), (g) and (h), am. (10) (a) and (b), Register, October, 1989, No. 406, eff. 1-1-90; renum. from Ins 3.51, Register, August, 1990, No. 416, eff. 9-1-90.

**Ins 3.53 HIV testing.** (1) **FINDINGS.** The tests listed in sub. (4) (e) 1 to 3 have been specified by the state epidemiologist in part C of a report entitled "Validated positive tests and medically significant and sufficiently reliable tests to detect the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV," dated August 31, 1990. 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 community-based organization in this state that provides AIDS prevention and education services to the general public and offers direct support services to persons with HIV infection at no cost.

(c) "ELISA" means enzyme-linked immunosorbent assay.

(d) "FDA-licensed test" means a test of a single whole blood, serum or plasma specimen which has been approved by the federal food and drug administration.

(e) "Health care provider" has the meaning given under s. 146.81 (1), Stats.

(f) "HIV" has the meaning given under s. 631.90 (1), Stats.

(g) "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.

(h) "State epidemiologist" has the meaning given under s. 146.025 (1) (f), Stats.

(i) "Wisconsin AIDSline" means the 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. 880, 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 26-002. It may be obtained from the Office of the Commissioner of Insurance, P.O. Box 7873, Madison, Wisconsin 53707-7873.

(e) The only tests an insurer may use under par. (a) are the following:

1. An FDA-licensed test that is positive for the presence of an HIV antigen.

2. An FDA-licensed ELISA test that is reactive for the presence of an antibody to HIV at least twice, followed by a reactive western blot test.

3. An FDA-licensed latex agglutination test that is positive for the presence of an antibody to HIV at least once, followed by a reactive western blot test.

(f) For purposes of par. (e) 2 and 3, a western blot test is reactive when any 2 of the following protein or glycoprotein bands are present:

1. p24.

2. gp41.

3. gp120 or gp160.

Note: Because of the difficulty of distinguishing the gp120 band from the gp160 band, the state epidemiologist has determined that the 2 glycoprotein bands may be considered as one reactant for the purpose of interpreting a western blot test.

(g) A test under par. (e) shall be performed by a laboratory that participates in and satisfies the standards of a generally recognized HIV proficiency testing program, including a program conducted by the federal centers for disease control, the American association of bioanalysts, the college of American pathologists or a similar program with specifications that meet the standards of those programs.

Note: An insurer may use any of the tests described in pars. (e) to (g), in underwriting individual life, accident and health insurance applications on and after May 1, 1991.

(h) 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 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 information on the medical implications of a positive test, the desirability of further independent testing and the availability of anonymous testing.

2. The toll-free telephone number of the Wisconsin AIDSline.

3. Copies 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.

Note: Subsections (4) (a) to (d), (5) and (6) first apply to applications taken on November 1, 1991.

(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 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.

Note: Subsections (6) (a), (b) and (e) and (7), as they exist on April 30, 1991, continue to apply to informed consent for testing and disclosure of test results until November 1, 1991.

History: Cr. Register, May, 1987, No. 377, eff. 6-1-87; r. and recr. Register, April, 1991, No. 424, eff. 5-1-91.



Ins 3.53  
APPENDIX A

[Insurer name and address]

WISCONSIN NOTICE AND CONSENT FOR AIDS-RELATED BLOOD  
TEST

## REQUEST FOR CONSENT FOR TESTING

To evaluate your insurability, \_\_\_\_\_ (insurer name) (Insurer) requests that you provide a sample of your blood for testing and analysis, 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 HIV counseling and testing site before signing this consent form. The Insurer is prohibited from asking you whether you have been tested at an anonymous HIV 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

Any test administered is not a test for AIDS. It is a test for antibodies to or antigens of HIV, the causative agent for AIDS, 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 HIV 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 AIDS-related blood testing. I voluntarily consent to the withdrawal of my blood, the testing of that blood, 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

**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.

Note: Section Ins 3.54 applies to disability insurance policies issued or renewed on or after June 1, 1987.

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) (d).

(cm) "Long-term care policy" has the meaning provided under s. Ins 3.46 (3) (e).

(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

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.