Clearinghouse Rule 98-098

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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Randy Blumer
Commissioner (Acting)

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STATE OF WISCONSIN)
) SS
OFFICE OF THE COMMISSIONER OF INSURANCE)

I, Randy Blumer, Commissioner of Insurance and custodian of the official records, certify that the annexed rule affecting Section Ins 3.27, 3.39 and 3.46, Wis. Adm. Code, relating to revising the requirements for medicare supplement policies to comply with recent federal and state laws and revising the definition of advertising for health insurance, is duly approved and adopted by this Office on November 30, 1998.

I further certify that I have compared this copy with the original on file in this Office and that it is a true copy of the original, and the whole of the original.

IN TESTIMONY WHEREOF, I have hereunto set my hand at 121 East Wilson Street, Madison, Wisconsin, on November 30, 1998.

Randy Blumer
Commissioner of Insurance

2-1-99
98-098

ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE REPEALING, AMENDING, REPEALING AND RECREATING AND CREATING A RULE

To repeal Ins 3.39 Appendix 8 (d), (e) and (f) and 3.46(9)(b); To amend Ins 3.27(5)(a)1., 3.39(4m)(a), (7)(b), (c) and (e), (9)(b) and (30)(i)9.; To repeal and recreate Ins 3.39 Appendix 1 and 4; and to create Ins 3.39(3)(akm), (aks), (akv), (cm) and (il), (4m)(c) and (d), (5)(c)16. and 17., (5)(k) and (m), (21)(f), (25)(d), (34) and Appendix 8 (al), (bl), (cl) and (gl), , Wis. Adm. Code, relating to revising requirements for medicare supplement policies to comply with recent federal and state laws.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

Statutory authority: ss. 601.41 (3), 625.16, 628.34 (12), 628.38, and 632.81, Stats.

Statutes interpreted: ss. 625.16, 628.34 (12), 628.38, and 632.81, Stats.

Most of these revisions update Wisconsin's medicare supplement regulations to conform to the revised National Association of Insurance Commissioner's model as required by federal law and to certain additional mandated benefits required by recent Wisconsin law changes.

The definition of advertisement for accident and health advertising is revised to specifically include electronic communications.

The definitions and qualifying conditions are defined for creditable coverage for purposes of requiring open enrollment to certain plans with sufficient creditable coverage from prior insurance coverage.

The rule clarifies that insurers must accept and process applications from people within 3 months prior to an open enrollment period. Some insurers have refused to accept applications from people prior to becoming eligible and made them apply after they are eligible thus causing undo hardship on them.

Wisconsin mandated coverages for facility charges related to some dental benefits and breast reconstruction are added to the basic medicare supplement policy.

Two new plans with high deductibles are defined as required by Federal law. These plans presumably would have lower premiums because of the high deductibles. The outline of coverage is modified to incorporate these plans.

Alternate disclosure statements now allowed by Federal law are incorporated into the rule and Medicare+Choice policies that do not meet the Wisconsin minimum coverage

requirements must disclose that they do not and specify the benefits not provided in the Outline of Coverage.

The commission limitations are removed for full-time, salaried employees of medicare replacement policies.

These revisions require guaranteed issue of certain medicare supplement plans for people who terminate from a defined employee welfare benefit plan, Medicare+Choice plans or isolvent issuers or nonissuer organizations.

The outline of coverage and the Notice of Changes in medicare are updated to reflect current requirements including a listing of which required coverages Meidcare+Choice policies do not contain.

The requirements for disclosure statements related to Long Term Care policies are eliminated.

SECTION 1. Section Ins 3.27(5)(a)1. is amended to read:

Ins 3.27(5)(a)1. Printed and published material, audio visual material and descriptive literature of an insurer used in newspapers, magazines, other periodicals, radio and TV scripts, the internet, web pages, electronic or computer presentations, billboards and similar displays, excluding advertisements prepared for the sole purpose of obtaining employes, agents or agencies.

SECTION 2. Sections Ins 3.39(3)(akm), (aks), (akv), (cm) and (il) are created to read:

Ins 3.39(3)(akm) "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than 63 days.

(aks)1. "Creditable coverage" means

with respect to an individual, coverage of the individual provided under any of the following:

a. A group health plan;

b. Health insurance coverage;

c. Part A or Part B of Title XVIII of the Social Security Act (medicare);

d. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928;

e. Chapter 55 of Title 10 United States Code, commonly referred to as CHAMPUS;

f. A medical care program of the Indian ServiceHealth Service or of a tribal organization;

g. A state health benefits risk pool;

h. A health plan offered under chapter 89 of Title 5 United States Code commonly referred to as the Federal Employees Health Benefits Program;

i. A public health plan as defined in federal regulation; and

j. A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

2. "Creditable coverage" does not include one or more, or any combination of, the following:

a. Coverage only for accident or disability income insurance, or any combination thereof;

b. Coverage issued as a supplement to liability insurance;

c. Liability insurance, including general liability insurance and automobile liability insurance;

d. Workers' compensation or similar insurance;

e. Automobile medical payment insurance;

f. Credit-only insurance;

g. Coverage for on-site medical clinics; and

h. Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

3. "Creditable coverage" does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

a. Limited scope dental or vision benefits;

b. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination; and

c. Such other similar, limited benefits as are specified in federal regulations.

4. "Creditable coverage" does not include the following benefits if offered as independent, noncoordinated benefits:

a. Coverage only for a specified disease or illness; and

b. Hospital indemnity or other fixed indemnity insurance.

5. "Creditable coverage" does not include the following if it is offered as a separate policy, certificate or contract of insurance:

a. Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

b. Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code; and

c. Similar supplemental coverage provided to coverage under a group health plan.

(akv) "Employee welfare benefit plan" means a plan, fund or program of employee benefits as defined in 29 U.S.C. s. 1002 (Employee Retirement Income Security Act).

(cm) "Medicare+Choice" plan means a plan of coverage for health benefits under Medicare Part C as defined in Section 1859 in Title IV, Subtitle A, Chapter 1 of P.L. 105-33, and includes:

1.Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;

2. Medical savings account plans coupled with a contribution into a Medicare+Choice medical savings account; and

3. Medicare+Choice private fee-for-service plans.

(il) "Secretary" means the secretary of the United States Department of Health and Human Services.

SECTION 3. Section Ins 3.39(4m)(a) is amended to read:

Ins 3.39(4m)(a) Unless the coverage is subject to sub. (7), an issuer may not deny or condition the issuance or effectiveness of, or discriminate in the pricing of, basic medicare supplement coverage, Medicare Select policies permitted under sub. (30) or riders permitted under sub. (5) (i) for which an application is submitted prior to or during the 6-month period beginning with the first month in which an individual first enrolled for benefits under Medicare Part B or the month in which an individual turns age 65 for any individual who was first enrolled in Medicare Part B when under the age of 65 on any of the following grounds:

SECTION 4. Sections Ins 3.39(4m)(c) and (d), (5)(c)16. and 17., (5)(k) and (m) are created to read:

Ins 3.39(4m)(c) If an applicant qualifies under par. (a) and submits an application during the time period referenced in par. (a) and, as of the date of application, has had a continuous period of creditable coverage of at least 6 months, the issuer may not exclude benefits based on a preexisting condition.

(d) If the applicant qualifies under par. (a) and submits an application during the time period referenced in par. (a) and, as of the date of application, has had a continuous period of creditable coverage that is less than 6 months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The secretary shall specify the manner of the reduction under this paragraph.

(5)(c)16. Payment in full for all usual and customary expenses of hospital and ambulatory surgery center charges and anesthetics for dental care required by s. 632.895(12), Stats. Issuers are not required to duplicate benefits paid by Medicare.

(5)(c)17. Payment in full for all usual and customary expenses for breast reconstruction required by s. 632.895(13), Stats. Issuers are not required to duplicate benefits paid by Medicare.

(5)(k) For the medicare supplement high deductible plan, the following:

1. The designation: MEDICARE SUPPLEMENT INSURANCE - HIGH DEDUCTIBLE PLAN

2. 100% of the covered benefits described in pars. (c), (i)1., (i)2., (i)3., (i)4. and (i)5 following the payment of the annual high deductible

3. The annual high deductible shall consist of out-of-pocket expenses, other than premiums, for services covered in subd. 2 and shall be in addition to any other specific benefit deductibles.

4. The annual high deductible shall be $1500 for 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

(5)(m) For the medicare supplement high deductible drug plan, the following:

1. The designation: MEDICARE SUPPLEMENT INSURANCE - HIGH DEDUCTIBLE DRUG PLAN

2. 100% of the covered benefits described in pars. (c), (i)1., (i)2., (i)3., (i)4., (i)5., and (i)7. following the payment of the annual high deductible

3. The annual high deductible shall consist of out-of-pocket expenses, other than premiums, for services covered in subd. 2 and shall be in addition to any other specific benefit deductibles.

4. The annual high deductible shall be $1500 for 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the secretary to reflect the change in

the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

SECTION 5. Sections Ins 3.39(7)(b), (c) and (e) and (9)(b) are amended to read:

Ins 3.39(7)(b) For a Medicare replacement policy or certificate, other than a policy subject to par. (a) and other than a Medicare+Choice MSA policy or certificate, 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~~ Medicare+Choice policy. A Medicare replacement policy or certificate shall include:

1. The designation: **~~MEDICARE RISK~~ MEDICARE+CHOICE 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 Risk~~ Medicare+Choice insurance. This policy does/does not meet ~~meets~~ all of these standards. For an explanation of these standards and other important information, see 'Wisconsin Guide to Health Insurance for People with Medicare,' given to you when you applied for this policy. Do not buy this policy if you did not get this guide."

3. In order to state that it meets all the standards under subpar. 2., the following minimum coverage, in addition to Medicare benefits:

(c) Each issuer which markets a ~~Medicare Risk~~ Medicare+Choice policy shall have an approved Medicare supplement insurance policy or Medicare Select policy available for all currently enrolled participants at the time as the contract between the Health Care Financing Administration and the issuer is terminated.

(e) Each Medicare+Choice issuer in order to state that it meets the minimum standards for Medicare+Choice policies set by this rule and each Medicare Cost issuer, shall offer the rider as described in sub. (5) (i) 2. and may offer the other riders as described in sub. (5) (i) and other coverages as authorized by the health care financing administration.

(9)(b) DISCLOSURE STATEMENTS. The appropriate disclosure statement from Appendix 8 shall be used on the application or together with the application for each coverage in pars. (c) to (e). The disclosure statement may not vary from the text or format including bold characters, line spacing, and the use of boxes around text contained in Appendix 8 and shall use a type size of at least 12 points. The issuer may use either (a) or (al), (b) or (bl), (c) or (cl) or (g) or (gl) providing the issuer uses the same disclosure statement for all policies of the type covered by the disclosure.

SECTION 6. Sections Ins 3.39(21)(f) and (25)(d) are created to read:

Ins 3.39(21)(f) Full time, salaried employees of insurers selling Medicare+Choice plans under par. (7)(b), are not subject to pars. (21)(a) and (b)

(25)(d) An agent may not take and an issuer may not accept an application from an insured more than 3 months prior to the insured becoming eligible.

SECTION 7. Section Ins 3.39(30)(i)9. is amended to read:

Ins 3.39(30)(i)9. The caption, except that the word "certificate" may be used instead of "policy," if appropriate: "The Wisconsin Insurance Commissioner has set standards for Medicare Select policies. This policy meets these standards. It, along with Medicare, may not cover all of your medical costs. You should review carefully all policy limitations. For an explanation of these standards and other important information, see `Wisconsin Guide to Health Insurance ~~Advice~~ for ~~Senior Citizens,~~ People with Medicare,' given to you when you applied for this policy. Do not buy this policy if you did not get this guide."

SECTION 8. Section Ins 3.39(34) is created to read:

Ins 3.39(34) GUARANTEED ISSUE FOR ELIGIBLE PERSONS

(a) Guaranteed Issue. 1. Eligible persons are those individuals described in par. (b) who apply to enroll under the policy not later than 63 days after the date of the termination of enrollment described in par. (b), and who submit evidence of the date of termination or disenrollment with the application for a medicare supplement policy.

2. With respect to eligible persons, an issuer may not deny or condition the issuance or effectiveness of a medicare supplement policy described in par. (c) that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a medicare supplement policy.

(b) Eligible Persons. An eligible person is an individual described in any of the following paragraphs:

1. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under medicare; and the plan terminates, or the plan ceases to provide some or all such supplemental health benefits to the individual;

2. The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under part C of medicare, and there are circumstances permitting discontinuance of the individual's election of the plan under the first sentence of section 1851(e)(4) of the federal Social Security Act, which consists of the following:

"Effective as of January 1, 2002, an individual may discontinue an election of a Medicare+Choice plan offered by a Medicare+Choice organization other than during an annual, coordinated election period [under Medicare] and make a new election under this section if:

1. The organization's or plan's certification [under this part] has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

2. The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;

3. The individual demonstrates, in accordance with guidelines established by the Secretary, that:

a. The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

b. The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

4. The individual meets such other exceptional conditions as the Secretary may provide."

3. a. The individual is enrolled with:

i. An eligible organization under a contract under Section 1876 (medicare risk or cost);

ii. A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

iii. An organization under an agreement under Section 1833(a)(1)(A) (health care prepayment plan); or

iv. An organization under a Medicare Select policy; and

b. The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under the first sentence of Section 1851(e)(4)of the federal Social Security Act as delineated above in subd. (b)2.

4. The individual is enrolled under a medicare supplement policy and the enrollment ceases because:

a. Of the insolvency of the issuer or bankruptcy of the nonissuer organization or of other involuntary termination of coverage or enrollment under the policy;

b. The issuer of the policy substantially violated a material provision of the policy; or

c. The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

5. a. The individual was enrolled under a medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare+Choice organization under a Medicare+Choice plan under part C of medicare, any eligible organization under a contract under Section 1876 (medicare risk or cost), any similar organization operating under demonstration project authority, an organization under an agreement under section 1833(a)(1)(A) (health care prepayment plan), or a medicare Select policy; and

b. The subsequent enrollment under subpar. a. is terminated by the enrollee during any period within the first 12 months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the federal Social Security Act); or

6. The individual, upon first becoming eligible for benefits under part A of medicare, enrolls in a Medicare+Choice plan under part C of medicare, and disenrolls from the plan by not later than 12 months after the effective date of enrollment.

(c) Products to Which Eligible Person are Entitled. The medicare supplement policy to which eligible persons are entitled under:

1. Subds. (34)(b)1., 2., 3., 4. and 6. is a medicare supplement policy as defined in sub (5) along with any riders available or a medicare Select policy as defined in sub. (30). except the Outpatient Prescription Drug rider defined in subd. (5)(i)7.

2. Subd. (34)(b)5. is the same medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy as described in subd 1.

(d) Notification provisions. 1. At the time of an event described in par. (b) because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of medicare supplement policies under par. (a). The notice shall be communicated contemporaneously with the notification of termination.

2, At the time of an event described in par. (b) because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the

contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of medicare supplement policies under par. (a). Such notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.

SECTION 9. Section Ins 3.39 Appendix 1 is repealed and recreated to read:

Ins 3.39 Appendix 1

(COMPANY NAME)

OUTLINE OF MEDICARE SUPPLEMENT INSURANCE

or

OUTLINE OF MEDICARE REPLACEMENT INSURANCE

(The designation and caption required by subd. (4)(b)4.)

PREMIUM INFORMATION

(1) We can only raise your premium if we raise the premium for all policies like yours in this state. [Include information specifying when premiums will change.]

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to (insert issuer's address). If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all your payments directly to you.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs.

(2) 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.

MEDICARE PART A — HOSPITAL SERVICES — PER BENEFIT PERIOD

Note: Issuers should include only the wording which applies to their policy's "This Policy Pays" column and complete the "You Pay" column.

A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Note: add the following text in a bold or contrasting color if the plan is a Medicare Medicare Supplement High Deductible Plan as defined in (5)(k) or (m): This high deductible plan offers benefits after one has paid a calendar year [$1500] deductible. This deductible consists of expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include [the plan's separate prescription drug deductible or] the plan's separate foreign travel emergency deductible.

SERVICES	PER BENEFIT PERIOD	MEDICARE PAYS	[AFTER YOU PAY A $1500 DEDUCTIBLE] PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous hospital services and supplies. Includes meals, special care units, recovery room, anesthesia and rehabilitation services.	First 60 days	All but $ (current deductible)	$0 or ☐ OPTIONAL PART A DEDUCTIBLE RIDER	
	61st to 90th days	All but $ (current amount per day)	$ (current amount per day)	
	91st to 150th days	All but $(current amount per day)	$ (current amount per day)	
	Beyond 150	Nothing	All	
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous hospital services and supplies. Includes meals, special care units, recovery room, anesthesia and rehabilitation services.	First 60 days	All but $ (current deductible)	$0 or ☐ OPTIONAL PART A DEDUCTIBLE RIDER	
	61st to 90th days	All but $ (current amount per day)	$ (current amount per day)	
	91st to 150th days	All but $(current amount per day)	$ (current amount per day)	
	Beyond 150	Nothing	All	
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies. Includes meals, special care units, recovery room, anesthesia and rehabilitation services.	First 60 days	All but $ (current deductible)	$0 or ☐ OPTIONAL PART A DEDUCTIBLE RIDER*	
	61st to 90th days	All but $ (current amount per day)	$ (current amount per day)	
	91st to 150th days	All but $(current amount per day)	$ (current amount per day)	
	Beyond 150	Nothing	All	
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital	First 20 days	100% of costs	$0	
	Additional 80 days	All but $ (current amount per day)	$ (current amount per day)	

Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital	First 20 days Additional 80 days	100% of costs All but $ (current amount per day)	$0 $ (current amount per day)	
Skilled Nursing Facility Care You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a medicare-approved facility within 30 days after leaving the hospital	First 20 days Additional 80 days	100% of costs All but $ (current amount per day)	$0 $ (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 ☐ OPTIONAL ADDITIONAL HOME HEALTH CARE RIDER	
Home health care		100% of charges for visits considered medically necessary by Medicare	40 visits or ☐ OPTIONAL ADDITIONAL HOME HEALTH CARE RIDER	
Home health care		100% of charges for visits considered medically necessary by medicare	40 visits or ☐ OPTIONAL ADDITIONAL HOME HEALTH CARE RIDER*	

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

MEDICARE SUPPLEMENT POLICIES - PART B BENEFITS

Note: Issuers should include only the wording which applies to their policy's "This Policy Pays" column and complete the "You Pay" column.

Once you have been billed $100 of Medicare approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Note: add the following text in a bold or contrasting color if the plan is a Medicare Medicare Supplement High Deductible Plan as defined in (5)(k) or (m): This high deductible plan offers benefits after one has paid a calendar year [$1500] deductible. This deductible consists of expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include [the plan's separate prescription drug deductible or] the plan's separate foreign travel emergency deductible.

MEDICARE PART B BENEFITS	PER CALENDAR YEAR	MEDICARE PAYS	[AFTER YOU PAY A $1500 DEDUCTIBLE] PLAN PAYS	YOU PAY
MEDICAL EXPENSES. Eligible expenses for physician's services, in-patient and out-patient medical services and supplies at a hospital, physical and speech therapy, ambulance, and outpatient psychiatric care.	Initial ($) deductible After initial deductible	$0 Generally 80%	Nothing Or ☐ OPTIONAL PART B DEDUCTIBLE RIDER* Generally 20% of medicare eligible charge and ☐ OPTIONAL MEDICARE PART B EXCESS CHARGES RIDER*	
Outpatient Prescription Drugs	Initial $6,250 deductible	$0 Generally does not cover prescription drugs	80% of charges over $6,250 and ☐ OPTIONAL MEDICARE OUTPATIENT PRESCRIPTION DRUG RIDER*	
Blood		80% of costs except nonreplacement fees(blood deductible) for first 3 pints (after $___ deductible / calendar year)	20% of all eligible costs and the first 3 pints in each calendar year	
Part B policy limits per calendar year			No limit	
Clinical Laboratory Services — Blood Tests For Diagnostic Services		100%	$0	

* 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.

(k) For Medicare+Choice policies, list any benefit required by Wisconsin law which is not covered by this policy

(6) CONSPICUOUS STATEMENTS AS FOLLOWS:

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "The Medicare Handbook" for more details.

(7) A description of policy provisions respecting renewability or continuation of coverage, including any reservation of rights to change premium.

(8) Information on how to file a claim for services received from non-participating providers because of an emergency within or outside of the service area shall be prominently disclosed.

(9) If there are restrictions on the choice of providers, a list of providers available to enrollees shall be included with the outline of coverage.

(10) A description of the review and appeal procedure for denied claims.

(11) The premium for the policy and riders, if any, in the following format:

MEDICARE SUPPLEMENT PREMIUM INFORMATION

Annual Premium

$ ( ) BASIC MEDICARE SUPPLEMENT COVERAGE

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 Difference between the Medicare eligible charge 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. Outpatient prescription drug charges At least 50% of the charges after a deductible of $ ____ (no more than $250) to a maximum benefit of $3,000 per year.
$ ( )	6. Foreign travel rider After a deductible not greater than $250, covers at least 80% of expenses associated with emergency medical care received outside the U.S.A. during the first 60 days of a trip with a maximum of at least $50,000
$ ( )	**TOTAL FOR BASIC POLICY AND SELECTED OPTIONAL BENEFITS**

(Note: The soliciting agent shall enter the appropriate premium amounts and the total at the time this outline is given to the applicant. Medicare Select policies and the SupplementMedicare Supplement High Deductible Plans 1 and 2 shall modify the outline to reflect the benefits which are contained in the policy and the optional or included riders.)

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

(13) Include a summary of or reference to the coverage required by applicable statutes.

(14) The term "certificate" should be substituted for the word "policy" throughout the outline of coverage where appropriate.

SECTION 10. Section Ins 3.39 Appendix 4 is repealed and recreated to read:

Ins 3.39 Appendix 4

(COMPANY NAME)
NOTICE OF CHANGES IN MEDICARE AND YOUR MEDICARE SUPPLEMENT COVERAGE — 19__

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

[Note: 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 19__ , Medicare Pays Per Benefit Period	Effective January 1, 19__ , Medicare Will Pay	In 19__ , Your Coverage Pays	Effective January 1, 19__ , Your Coverage Will Pay Per Calendar Year
MEDICARE PART A SERVICES AND SUPPLIES				
Inpatient Hospital Services Semi-Private Room & Board	All but $__ for the first 60 days/benefit period	All but $__ for the first 60 days/benefit period		
Misc. Hospital Services & Supplies, such as Drugs, X-Rays, Lab Tests & Operating Room	All but $__ a day for 61st- 90th days/benefit period	All but $__ a day for 61st- 90th days/benefit period		
	All but $ _ a day for 91st- 150th days (if individual chooses to use 60 nonrenewable lifetime reserve days)	All but $ _ a day for 91st- 150th days (if individual chooses to use 60 nonrenewable lifetime reserve days)		
BLOOD	Pays all costs except payment of deductible (equal to costs for first 3 pints) each calendar year. Part A blood deductible reduced to the extent paid under Part B	Pays all costs except nonreplacement fees (blood deductible) for first 3 pints of each benefit period	80% of all costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period (After $__ deductible/ calendar year)	80% of costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period (after $ _deductible/ calendar year)
SKILLED NURSING FACILITY CARE	Skilled nursing care in a facility approved by Medicare. Confinement must meet Medicare standards. You must have been in a hospital for at least three days and enter the facility within 30 days after discharge.			
	First 20 days 100% of costs	First 20 days 100% of costs		

Additional 80 days all but $__ (current amount per day)	Additional 80 days all but $__ (current amount per day)

MEDICARE PART B SERVICES AND SUPPLIES

80% of allowable charges (after $__ deductible calendar year)	80% of allowable charges (after $__ deductible)

[Note: Describe any coverage provisions changing due to Medicare modifications. Include information about when premium adjustments that may be necessary due to changes in Medicare benefits will be effective.]

THIS CHART 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]

SECTION 11. Sections Ins 3.39 Appendix 8 (al), (bl), (cl) and (gl) are created to read:

INS 3.39 Appendix 8 (al) [Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(bl) [Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(cl) [Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(gl) [Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

SECTION 12. Sections Ins 3.39 Appendix 8 (d), (e) and (f) are repealed.

SECTION 13. Section Ins 3.46(9)(b) is repealed.

SECTION 14. These changes first apply to policies issued, renewed or solicited after January 1, 1999.

SECTION 15. These changes will take effect on January 1, 1999, as provided in s. 227.22(2)(b), Stats.

Dated at Madison, Wisconsin, this 30th day of November, 1998.

Randy Blumer, Commissioner of Insurance