Chapter Ins 3

CASUALTY INSURANCE

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

Ins 3.02 Automobile fleets, vehicles not included in. Individually owned motor vehicles cannot be included or covered by fleet rates. The determining factor for inclusion under fleet coverage must be ownership and not management or use.

Ins 3.04 Dividends not deducted from premiums in computing loss reserves. Premiums returned to policyholders as dividends may

not be deducted from the earned premiums in computing loss reserves under s. 623.04, Stats.

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

Ins 3.09 Mortgage guaranty insurance. (1) PURPOSE. This rule implements and interprets, including but not limited to, s. Ins 6.75 (2) (i) and ss. 611.02, 611.24, 618.01, 618.21, 620.02 and 623.04, 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).

(3) DEFINITIONS. (a) Mortgage guaranty insurance is that kind of insurance authorized by s. Ins 6.75 (2) (i), and includes the guarantee of the payment of rentals under leases of real estate in which the lease extends for 3 years or longer.

(b) As used in this rule, "person" means any individual, corporation, association, partnership or any other legal entity.

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

(5) LIMITATION OF TOTAL LIABILITY ASSUMED. A mortgage guaranty insurer shall not at any time have outstanding a total liability under its aggregate insurance policies, computed on the basis of its election to limit coverage and net of reinsurance assumed and of reinsurance ceded to an insurer authorized to transact such reinsurance in this state, exceeding 25 times the sum of its contingency reserve established under sub. (14) and its surplus as regards policyholders.

(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 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.

(8) REINSURANCE. A mortgage guaranty insurer may, by contract, reinsure any insurance it transacts in any assuming insurer authorized to transact mortgage guaranty insurance in this state, except it shall not

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 sugical 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) The provision or notice regarding the right to return the policy required by s. 632.73, Stats., shall:

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

2. have a caption or title which refers at least to the right to examine or to return the policy such as: "Right to Return Policy Within 10 Days of Receipt", "Notice: Right to Return Policy", "Right of Policy Examination", "Right to Examine Policy", "Right to Examine Policy for 10 Days", "10 Day Right to Examine Policy", "10 Day Right to Return Policy", or "Notice of 10 Day Right to Return Policy", or other wording,

subject to approval by the commissioner, which is believed to be equally clear or more definite as to subject matter, and

3. provide an unrestricted right to return the policy, within 10 days from the date it is received by the policyholder, to the insurer at its home or branch office, if any, or to the agent through whom it was purchased. 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) 8., Stats., to the review of accident and sickness policy and other contract forms. The statute requires that the provision or 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 statute permits the insured to return his or her policy for refund to the home office or branch office of the insurer or to the agent through whom it was purchased. In order to assure that refund is made promptly, some insurers prefer to instruct the insured to return the policy to a particular office or agent for 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 his policy for refund within 10 days from the date he receives it. 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 a refund if the insured returns the policy within 10 days from the date of receipt.

All present tense statutory references herein are to 1973, Stats.

(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 that 12-point type. Such notice shall be worded in one of the following ways:

"Notice! See Elmination 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"

"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 Wis. Adm. Code section 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. Subsection (6), paragraphs (b) 3 and (b) 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.

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 (34m) (b), Stats.

(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 (34m) (b), 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.

policies 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,

(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,

(j) Change to a Medicare supplement policy which covers pre-existing conditions, without any limitation, to replace a basic hospital expense, basic medical expense, basic surgical expense, or major-medical expense policy.

(4) DEFINITIONS. For the purposes of this rule:

(a) *Replacement* is any transaction wherein new accident and sickness insurance is to be purchased, and it is known to the agent or company at the time of application that as part of the transaction, existing accident and sickness insurance has been or is to be lapsed or the benefits thereof substantially reduced.

(b) *Continuous coverage* means that the benefits are not less than the benefits under the previous policy, and the policy also covers loss resulting from injury sustained or sickness contracted while coverage was in force under the previous policy to the extent such loss is not covered under any extended benefit or similar provision of the previous policy.

(c) *Group type coverage* is as defined in 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) 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.

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.

3. Questions in the application for the new policy must be answered truthfully and completely; otherwise, the validity of the policy and the payment of any benefits thereunder may be voided.

4. The new policy will be issued at a higher age than that used for issuance of your present policy; therefore, the cost of the new policy,

depending upon the benefits, may be higher than you are paying for your present policy.

5. The renewal provisions of the new policy should be reviewed so as to make sure of your rights to periodically renew the policy.

6. It may be to your advantage to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. You should be certain that you understand all the relevant factors involved in replacing your present coverage.

The above "Notice to Applicant" was delivered to me on- - - - - - - -. (date)

- - - - - - - - - -
Applicant

(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.

(9) SEPARABILITY. If any provision of this rule shall be held invalid, the remainder of the rule shall not be affected by such invalidity.

(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.

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 nonprofit 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.

b. An insurer shall give due consideration to all statements in each enrollment form for insurance submitted to it and shall duly evaluate the proposed insured person before issuing evidence of coverage for such person.

c. An insurer which issues evidence of coverage for a person shall not use the statements, information or material set out in subds. 1, 2 and 3 to

prohibiting special favors to certain customers. It is not intended to preclude reasonable and customary business entertainment and trade association activities and expense incurred by the title insurer in the course of marketing its products and services. Moderate expenditures for food, meals, beverages and entertainment may be made, if correctly claimed and properly substantiated as a legitimate business expense.

(p) Paying for, or offering to pay for, money, prizes or other things of value for any such person in any kind of a contest or promotional endeavor. This prohibition applies whether or not the offer or payment of a benefit relates to the number of title orders placed or escrows opened with a title insurer or group of such insurers. It does not apply to offers or payments to trade associations, charitable or other functions where the thing of value is in the nature of a contribution or donation rather than a business solicitation.

(q) Paying for, or offering to pay for, any advertising concerning the title insurer which is to appear in a pamphlet, magazine, brochure, or any other advertising material promoted or distributed, with or without cost by any such person. Examples of this kind of advertising material are advertisements appearing in newsletters distributed by real estate brokers, tract brochures issued by land developers or builders, or jointly sponsored promotional magazines. This prohibition does not apply to brochures or other promotional items of the title insurer used in the marketing of its own products, to advertising in trade media or other media not promoted or solicited by such persons, nor to other forms of advertising provided the expected benefit to be derived from customers generally is fairly equivalent to the expense incurred.

(r) Paying for or furnishing, or offering to pay for or furnish any brochures, billboards, or advertisements of such persons, 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, any such person.

(5) PENALTY. Any violation of this rule shall subject the title insurer to the penalties and forfeitures provided by s. 601.64, Stats.

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.

Ins 3.36 Statistical reports—health professional liability insurance. History: Emerg. cr. eff. 1-20-76; cr. Register, March, 1976, No. 243, eff. 4-1-76; r. March, 1982, No. 315, eff. 4-1-82.

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 abnormalties of the newborn infant to the extent that such covered occurrences, losses, services or expenses would not have been necessary for the routine postnatal care of the newborn child in the absence of such injury or sickness. In addition, under a policy providing coverage for hospital confinement and/or in-hospital doctor's charges, hospital confinement from birth 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.

(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.

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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 accident and sickness insurance sold to the Medicare eligible. (1) PURPOSE. (a) This rule establishes minimum requirements for accident and sickness insurance which may be sold to Medicare eligible persons as Medicare supplement coverage. A policy will be approved by the commissioner as a Medicare supplement if it contains the Designation and Caption that is appropriate for the level of coverage that policy provides. A policy that is designed or structured as a supplement to Medicare will be disapproved pursuant to s. 631.20, Stats., if that policy does not meet the minimum requirements of any of the 4 classes of Medicare supplement insurance specified in this rule. Disclosure provisions are also established for other accident and sickness policies sold to Medicare eligible persons, because such policies frequently have been represented to, and purchased by, the Medicare eligible as supplements to Medicare.

(b) This rule seeks to reduce abuses and confusion associated with the sale of accident and sickness insurance to Medicare eligible persons by providing for clearly defined categories of Medicare supplement insurance and reasonable minimum levels of coverage for each category. The disclosure requirements and categories established are intended to provide to Medicare eligible persons guidelines that can be used to compare Medicare supplement insurance policies on the market and to aid them in the purchase of Medicare supplement coverage which is suitable for their needs. The rule is designed not only to improve the ability of the Medicare eligible consumer to make an informed choice when purchasing a Medicare supplement policy, but also to assure the Medicare eligible persons of this state that no policy will be approved by the Commissioner as a "Medicare supplement policy" unless it contains coverage which warrants the use of that label.

(c) Wisconsin statutes interpreted and implemented by this rule include but are not limited to ss. 601.01 (3) (b), 631.20 (2), 631.23 and 628.34 (11).

(2) SCOPE. This rule applies to any individual accident and sickness insurance coverage sold to the Medicare eligible which relates its benefits to Medicare, is designed to complement Medicare or is advertised or marketed as a supplement to Medicare, including any contracts purporting to offer comprehensive medical or surgical coverage sold predominantly to the Medicare eligible. This rule also applies to individual hospital confinement indemnity coverage, nursing home coverage and specified disease coverage sold to Medicare eligible. Except for subsection (8), this rule does not apply to conversion contracts offered as replacements for prior individual or group coverage or to individual or group coverage which continues after an insured becomes eligible for Medicare.

(3) DEFINITIONS. For the purpose of this rule:

(a) *Medicare* means the hospital (part A) and medical (part B) insurance program established by title XVIII of the federal social security act of 1965, as amended.

(b) *Medicare eligible persons* include all persons who qualify for Medicare.

(c) *Medicare eligible expenses* are health care expenses of the type covered by Medicare, which may or may not be fully reimbursed by Medicare.

(d) *Medicare supplement coverage* means hospital, surgical or medical expense incurred and/or indemnity coverage which relates its coverage to eligibility for Medicare and which is designed to pay a specific deductible or co-payment requirement imposed under Medicare Parts A and/or B and provide coverage beyond what Medicare provides, and which conforms to subsection (5) of this rule.

(e) *Hospital confinement indemnity coverage* means coverage as defined in Wisconsin Administrative Code section Ins 3.27 (4) (b) 6.

(f) *Specified disease coverage* means coverage which is limited to named or defined sickness conditions. Such coverage does not include dental or vision care coverage.

(g) *Nursing facility* means an institution which provides professional convalescent or rehabilitative services and which is licensed by the State of Wisconsin.

(h) *Outline of coverage* means an appropriately captioned or titled printed statement which meets the requirements of Wis. Adm. Code section Ins 3.27 (5) (l) and of subsection (4) (b) of this rule.

(i) Terms such as "skilled nursing facility" and "benefit period" used in this rule shall be as defined by Medicare. Terms used in Medicare supplement policies shall be worded no less favorably to the insured person than the corresponding Medicare definition.

(4) MEDICARE SUPPLEMENT POLICY REQUIREMENTS. No accident and sickness insurance policy comprehended by this rule shall relate its coverage to Medicare or be structured, advertised or marketed as a supplement to Medicare unless:

(a) The policy:

1. Provides at a minimum the coverage set out in subsection (5) and applicable statutes;

2. Contains no pre-existing condition waiting period longer than 12 months except that a condition may be excluded from coverage by name or specific, non-generic description, effective on the date expenses are incurred; and

3. Contains in close conjunction on its first page the Designation, printed in capitals in a clear, contrasting ink in 18-point type of a style in general use, and the Caption, printed in a clear, contrasting ink in 12-point type of a style in general use, prescribed in subsection (5); and

4. Is plainly printed as to text in black or blue ink in type of a style in general use, the size of which is uniform and not less than 10-point with a lower-case unspaced alphabet length not less than 120-point.

(b) The outline of coverage for the policy:

1. Contains a clearly worded and organized chart or charts:

a. Summarizing the benefits provided by Medicare Parts A and B;

b. Summarizing the Medicare supplement benefits provided by the policy; and

c. Indicating what Medicare eligible expenses remain uncovered by Medicare and the policy;

2. Complies with sections Ins 3.27 (5) (l) and Ins 3.27 (9) (u), (v) and (zh) 2 and 4;

3. Contains conspicuous statements:

a. That Medicare will not pay for charges it deems "unreasonable and unnecessary";

b. Unless the policy explicitly provides otherwise, that the policy will not pay for charges deemed "unreasonable and unnecessary" by Medicare;

c. Unless the policy explicitly provides otherwise, that the policy will not cover expenses outside of Medicare such as routine doctor examinations or eye glasses;

d. That the chart summarizing Medicare benefits only briefly describes the program; and

e. That the federal social security administration or its Medicare publications should be consulted for further details and limitations regarding Medicare;

4. Contains in a close conjunction on its first page the Designation, printed in capitals in a clear, contrasting ink in 24-point type of a style in general use, and the Caption, printed in a clear, contrasting ink in 18-point type of a style in general use, prescribed in subsection (5);

5. Complies with (7) (b) 1.; and

6. Summarizes or refers to the coverage set out in applicable statutes; and

7. Is submitted to the commissioner for approval along with the policy form.

(5) AUTHORIZED MEDICARE SUPPLEMENT POLICY DESIGNATIONS, CAPTIONS AND MINIMUM COVERAGES. For a policy to meet the requirements of subsection (4), it must contain the authorized Designation, Caption and Minimum Coverage prescribed for one of the following categories of Medicare Supplement insurance.

(a) A MEDICARE SUPPLEMENT 1 policy must include:

1. The following Designation: MEDICARE SUPPLEMENT 1

2. The following Caption: The State Insurance Commissioner's Office has established three categories of Medicare Supplement insurance and minimum benefit standards for each. These categories range from the most comprehensive (Medicare Supplement 1) to the least comprehensive (Medicare Supplement 3). For an explanation of the differences between this "1" policy and policies in the other categories, consult the commissioner's pamphlet "Health Insurance Advice for Senior Citi-

zens" which you received with the application for this policy. Do not buy this policy if you did not get this pamphlet and were not given a chance to review the Outline of Coverage provided you.

3. The following Minimum Coverage: This level of coverage shall at a minimum cover all Medicare eligible expenses listed below to at least a stated maximum of $22,500 per benefit period (inclusive of Medicare Parts A and B) or $15,000 per benefit period for Medicare Part A and $7,500 per calendar year for Medicare Part B. Benefits shall be provided for the enumerated expenses up to the stated maximum beyond the day limitations established by Medicare unless a minimum period is specified below.

a. The following Medicare Part A eligible expenses:

1) Hospitalization, including inpatient psychiatric care

2) Extended Care Services in a Skilled Nursing Facility

3) Home Health Care (post-hospital)

4) Blood

b. The following Medicare Part B eligible expenses:

1) Physician's services (except for routine physical examinations)

2) Home Health Care

3) Outpatient Hospital Services

i. Services in an emergency room or outpatient clinic

ii. Laboratory tests billed by a hospital

iii. X-rays and other radiology services billed by a hospital

iv. Medical supplies such as splints and casts

v. Drugs and biologicals which cannot be self-administered

4) Outpatient Physical Therapy and Speech Pathology Services

5) Other Health Services and Supplies

i. Diagnostic x-rays and independent laboratory tests

ii. Ambulance

iii. Medical supplies

iv. Prosthetic devices

v. Durable medical equipment

vi. Portable diagnostic x-ray services

6) Blood

c. Coverage shall be provided for at least 75% of prescription drug expenses and 50% of outpatient psychiatric treatment up to a separate lifetime maximum of at least $1,000.

(b) A MEDICARE SUPPLEMENT 2 policy must include:

1. The following Designation: MEDICARE SUPPLEMENT 2

2. The following Caption: The State Insurance Commissioner's Office has established three categories of Medicare Supplement insurance and minimum benefit standards for each. These categories range from the most comprehensive (Medicare Supplement 1) to the least comprehensive (Medicare Supplement 3). For an explanation of the differences between this "2" policy and policies in the other categories, consult the Commissioner's pamphlet "Health Insurance Advice for Senior Citizens" which you received with the application for this policy. Do not buy this policy if you did not get this pamphlet and were not given a chance to review the Outline of Coverage provided you.

3. The following Minimum Coverage: This level of coverage shall at a minimum cover all Medicare eligible expenses listed below to at least a stated maximum of $15,000 per benefit period (inclusive of Medicare Parts A and B) or $10,000 per benefit period for Medicare Part A and $5,000 per calendar year for Medicare Part B. Benefits shall be provided for the enumerated expenses up to the stated maximum beyond the day limitations established by Medicare.

a. The following Medicare Part A eligible expenses:

1) Hospitalization, including inpatient psychiatric care

2) Extended Care Services in a Skilled Nursing Facility

3) Home Health Care (post-hospital)

b. The following Medicare Part B eligible expenses:

1) Physician's services (except for routine physical examinations)

2) Home Health Care

3) Outpatient Hospital Services

i. Services in an emergency room or outpatient clinic

ii. Laboratory tests billed by a hospital

iii. X-rays and other radiology services billed by a hospital

iv. Medical supplies such as splints and casts

v. Drugs and biologicals which cannot be self-administered

4) Outpatient Physical Therapy and Speech Pathology Services

5) Other Health Services and Supplies

i. Diagnostic x-rays and independent laboratory tests

ii. Ambulance

iii. Medical supplies

(c) A MEDICARE SUPPLEMENT 3 policy must include:

1. The following Designation: MEDICARE SUPPLEMENT 3

2. The following Caption: The State Insurance Commissioner's Office has established three categories of Medicare Supplement insurance and minimum benefit standards for each. These categories range from the

most comprehensive (Medicare Supplement 1) to the least comprehensive (Medicare Supplement 3). For an explanation of the differences between this "3" policy and policies in the other categories, consult the Commissioner's pamphlet "Health Insurance Advice for Senior Citizens" which you received with the application for this policy. Do not buy this policy if you did not get this pamphlet and were not given a chance to review the Outline of Coverage provided you.

3. The following Minimum Coverage: This level of coverage shall at a minimum cover all Medicare eligible expenses listed below to at least a stated maximum of $6,500 per benefit period (inclusive of Medicare Parts A and B) or $5,000 per benefit period for Medicare Part A and $1,500 per calendar year for Medicare Part B. Benefits shall be provided for the enumerated expenses up to the stated maximum beyond the day limitations established by Medicare unless a minimum period is specified below.

a. The following Medicare Part A eligible expenses:

1) Hospitalization to the 90th day of confinement including inpatient psychiatric care

2) Co-payment for each of 30 lifetime reserve days of hospital confinement

3) Extended Care Services in a Skilled Nursing Facility to the 100th day of confinement

b. The following Medicare Part B eligible expenses:

1) Physician's services (except for routine physical examinations)

2) Outpatient Hospital Services

i. Services in an emergency room or outpatient clinic (not including physical therapy or speech pathology)

ii. Laboratory tests billed by a hospital

iii. X-rays and other radiology services billed by a hospital

iv. Medical supplies such as splints and casts

3. Ambulance

(6) PERMISSIBLE MEDICARE SUPPLEMENT POLICY EXCLUSIONS AND LIMITATIONS. (a) The coverages set out in subsection (5) may:

1. Exclude expenses for which the insured is compensated by Medicare.

2. Exclude coverage for the initial deductibles for Medicare Parts A and B.

3. Include any exclusion or condition contained in Medicare, except that inhospital treatment of mental illness shall be covered the same as any other illness.

4. Contain an appropriate provision relating to the effect of other insurance on claims.

5. Except for a Medicare Supplement 1 policy for which a specific requirement is set out in subsection (5) (a) 3. c., limit coverage of outpatient psychiatric treatment to 50% of the reasonable and necessary charges and to a lifetime benefit of $500.

6. Contain a pre-existing condition waiting period provision as provided in subsection (4) (a) 2.

(b) Where the insured chooses not to enroll in Medicare Part B, the insurer may exclude from coverage the expenses which Medicare Part B would cover. Medicare Part B expenses incurred beyond what Medicare Part B would cover may not be excluded.

(7) NURSING HOME, HOSPITAL CONFINEMENT INDEMNITY AND SPECIFIED DISEASE COVERAGES. (a) Captions for the policies listed in 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 capital letters.

(b) Nursing Home Coverage. A policy form providing coverage for care in a nursing home shall meet the standards set forth in s. Ins 3.46, Wis. Adm. Code. Such a policy sold to Medicare-eligible persons shall bear the following caption: THE NURSING HOME BENEFIT OF THIS POLICY DOES NOT RELATE IN ANY WAY TO MEDICARE. FOR MORE INFORMATION, CONSULT THE COMMISSIONER'S PAMPHLET "HEALTH INSURANCE ADVICE FOR SENIOR CITIZENS" WHICH YOU RECEIVED WITH THE APPLICATION FOR THIS POLICY.

(c) Hospital Confinement Indemnity Coverage. A policy form providing hospital confinement indemnity coverage sold to a Medicare eligible person shall bear the following Caption: THE HOSPITAL CONFINEMENT INDEMNITY BENEFIT OF THIS POLICY IS NOT DESIGNED TO FILL THE GAPS IN MEDICARE. IT WILL PAY YOU ONLY A STATED DOLLAR AMOUNT FOR A DESIGNATED NUMBER OF DAYS WHEN YOU ARE HOSPITAL CONFINED. FOR MORE INFORMATION, CONSULT THE COMMISSIONER'S PAMPHLET "HEALTH INSURANCE ADVICE FOR SENIOR CITIZENS" WHICH YOU RECEIVED WITH THE APPLICATION FOR THIS POLICY.

(d) Specified Disease Coverage. A policy form providing benefits only for one or more specified diseases sold to a Medicare eligible person shall bear:

1. The following Designation: SPECIFIED OR RARE DISEASE LIMITED POLICY, and

2. The following Caption: THIS POLICY IS DESIGNED TO COVER ONLY ONE OR MORE SPECIFIED OR RARE ILLNESSES. IT SHOULD NOT BE PURCHASED AS A SUBSTITUTE FOR HEALTH CARE EXPENSE COVERAGE WHICH WOULD GENERALLY COVER ANY ILLNESS OR INJURY. FOR MORE INFORMATION, CONSULT THE COMMISSIONER'S PAMPHLET

"HEALTH INSURANCE ADVICE FOR SENIOR CITIZENS" WHICH YOU RECEIVED WITH THE APPLICATION FOR THIS POLICY.

(8) CONVERSION OR CONTINUATION OF COVERAGE. (a) An Outline of Coverage as described in par. (e) and a copy of the current edition of the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" shall be furnished by an insurer upon request to each insured who will become eligible for Medicare and is offered a conversion policy under the terms of a group insurance policy.

(b) An insurer:

1. Which provides group insurance coverage shall furnish annually to each group policyholder written notice of the availability of the information described in pars. (a) or (d), where applicable, and upon request shall furnish sufficient copies of the same or similar notice to the group policyholder to be distributed to group members affected; and

2. Which provides individual or family insurance coverage shall furnish an Outline of Coverage as described in par. (e) and a copy of the current edition of the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" at the time an insured who will become eligible for Medicare is furnished an application for conversion.

(c) Except as provided under par. (d), an insurer shall furnish an Outline of Coverage and a copy of the current edition of the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" within 14 calendar days after receipt of the request for such information.

(d) Upon request, a comprehensive written explanation of the insurance coverage to be provided after Medicare eligibility and a copy of the current edition of the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" shall be furnished by the insurer within 14 calendar days after receipt of the request to each insured who will become eligible for Medicare whose coverage under an individual, family or group insurance policy will continue with changed benefits (e.g. "carve-out" or reduced benefits).

(e) The Outline of Coverage:

1. For a conversion policy which relates its benefits to or complements Medicare shall comply with subsection (4) (b) 1., 2., 3., and 6. of this rule and shall be submitted to the commissioner; and

2. For a conversion policy not subject to subd. 1. shall comply with subsection (7), where applicable, and section Ins 3.27 (5) (1).

(9) "HEALTH INSURANCE ADVICE FOR SENIOR CITIZENS" PAMPHLET. Every prospective Medicare eligible purchaser of any policy subject to this rule or coverage added to an existing Medicare Supplement policy must 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 Ins 3.27 (5) (g). This pamphlet prepared by the Office of the Commissioner of Insurance provides information on Medicare and advice to senior citizens on the purchase of Medicare supplement insurance and other health insurance. Insurers may obtain copies of this pamphlet from the commissioner at cost or may reproduce this pamphlet

themselves. This pamphlet shall 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 received notice that the revised pamphlet is available at the commissioner's office.

(10) APPROVAL NOT A RECOMMENDATION. While the commissioner may authorize the use of a particular Designation on a policy in accordance with this rule, that authorization is not to be construed or advertised as a recommendation of any particular policy by the commissioner or the state of Wisconsin.

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

(12) EFFECTIVE DATE. This rule shall take effect January 1, 1978.

History: Cr. Register, July, 1977, No. 259, eff. 8-1-77; am. (13), Register, September, 1977, No. 261, eff. ~~10-1-77~~; 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.

Ins 3.40 Authorized clauses for coordination of benefit provisions in group and blanket disability insurance policies [ss. 631.20, 631.21 (1) (b), 631.23, 631.43, 632.77 (3)]. (1) PURPOSE. This section establishes authorized coordination of benefit clauses for group and blanket disability insurance policies pursuant to s. 631.23, Stats., because it has been found that provision of language, content or form of these specific clauses is necessary to provide certainty of meaning of them, and regulation of contract forms will be more effective and litigation will be substantially reduced is there is increased uniformity of these clauses. This section does not require the use of coordination of benefit or "other insurance" provisions but if such provisions are used, they must adhere substantially to this section. Liberalization of the prescribed language including rearrangement of the order of the clauses is permitted provided that the modified language is not less favorable to the insured person. Provisions for the reduction in benefits because of other insurance which are inconsistent with this section violate the criteria of s. 631.20, Stats., and may not be used.

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

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

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

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

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

that significant misunderstanding exists with respect to nursing home insurance. In many cases, coverage under these policies is much less than the use of the label would warrant and includes few meaningful benefits beyond those already available to consumers as a result of s. 632.78 (4), Stats., and Ins 3.39, Wis. Adm. Code, and the commissioner of insurance finds that such policies are inequitable, misleading, deceptive, obscure, and encouraging of misrepresentation as considered by s. 631.20 (2), Stats. Some of the sales presentations used to sell nursing home insurance are misleading, confusing, and incomplete, and the commissioner of insurance finds that such presentations are misleading and deceptive, and restrain competition unreasonably under s. 628.34 (12), Stats., and their continued use would constitute an unfair trade practice under s. 628.34 (11), Stats.

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

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

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

(b) This section shall not apply to a rider designed specifically to meet the requirement for coverage of skilled nursing care set forth in s. 632.78 (4), Stats.

(4) DEFINITIONS. For the purpose of this section:

(a) "Medicare" means the hospital and medical insurance program established by title XVIII of the federal social security act of 1965, as amended.

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

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

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

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

(b) The policy is plainly printed as to text in black or blue ink in a type of a style in general use, the size of which is uniform and not less than 10 point with a lower case unspaced alphabet length not less than 120 point.

(c) If the policy is sold to Medicare-eligible persons, it meets the requirements of s. Ins 3.39 (7) (b), Wis. Adm. Code.

(6) MINIMUM COVERAGES. (a) Except as provided in pars. (b) through (g) of this section, a nursing home policy shall provide coverage for each person insured under the policy for any care received while a resident of any nursing home licensed by the state of Wisconsin pursuant to s. 50.02, Stats.

(b) Nursing home policies may limit benefits to a fixed daily benefit. The daily benefit may differ for different levels of care, but the lowest level of daily benefits shall not be less than $10 a day.

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

(d) Nursing home policies may provide benefits subject to a lifetime maximum, but the lifetime maximum shall be at least 365 days of coverage.

(e) Nursing home policies may limit coverage to care certified as necessary by the attending physician and periodically recertified as necessary.

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

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

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

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

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

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

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

History: Cr. Register, June, 1981, No. 305, eff. 11-1-81.

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

(2) PURPOSE. The purpose of s. Ins 3.47 is to promulgate a rule interpreting s. 628.34 (12), relating to unfair trade practices. It requires insurers and intermediaries who sell cancer insurance to give all prospective buyers of cancer insurance a buyer's guide prepared by the National Association of Insurance Commissioners.

(3) SCOPE. This section applies to all individual, group and franchise insurance polices or riders which provide benefits for or are advertised as providing benefits primarily for the treatment of cancer. This rule does not apply to solicitations in which the booklet, "Health Insurance Advice for Senior Citizens," is given to applicants as required by s. Ins 3.39, Wis. Adm. Code.

(4) DEFINITION. The "Information Sheet on Cancer Insurance" means the document which contains, and is limited to, the language set forth in Appendix I to this section.

(5) DISCLOSURE REQUIREMENTS. (a) The insurer and its intermediaries shall print and provide to all prospective purchasers of any policy subject to the rule a copy of the "Information Sheet on Cancer Insurance" at the time the prospect is contacted by an intermediary or insurer with an invitation to apply as defined in s. Ins 3.27 (5) (g), Wis. Adm. Code.

(b) The "Information Sheet on Cancer Insurance" shall be printed in an easy to read type and not less than 12 pt. size.

(6) This rule shall become effective August 1, 1981.

History: Cr. Register, June, 1981, No. 306, eff. 8-1-81.

APPENDIX I

INFORMATION SHEET ON CANCER INSURANCE

Cancer Insurance is Not a Substitute for Comprehensive Coverage.

Should You Buy Cancer Insurance?

Caution: Limitations On Cancer Insurance.

Prepared by the National Association of Insurance Commissioners

CANCER INSURANCE . . .

Cancer insurance is one of the fastest growing and most controversial forms of health insurance. It 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 less than 6% 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, 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 neeed 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. 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. For 1978, the average hospital cost for cancer treatment was $4,228. 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 one in four Americans will get cancer over a lifetime, three in four will not. In any one year, only one American in 285 will get cancer. The odds are against a Policyholder receiving any benefits.

CAUTION: LIMITATIONS OF CANCER INSURANCE . . .

Cancer policies sold today vary widely in cost and coverage. 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 16 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, 99% of all cancer patients spend less than 60 days in the hospital. 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. If you do not get the information you want, discuss the matter with your State Insurance Department.

(b) "Fees", "operating fees" or "annual fees" means those fees charged for each fiscal year of participation, July 1 to June 30.

(c) "Class" of physicians or surgeons means those classes currently in use by the Wisconsin Health Care Liability Insurance Plan, as authorized by s. Ins 17.25 (12) (b), Wis. Adm. Code.

(4) PRO RATA FEES. A health care provider may enter or exit the Fund at a date other than July 1 or June 30.

(a) If a health care provider enters the Fund subsequent to July 1, the provider shall be charged a fee of one-twelfth the annual fee for that class of provider for each month or part of month between the date of entry and the next June 30.

(b) Notwithstanding the provisions of par. (a) no fee shall be charged for entry to the Fund after each June 1.

(c) If a health care provider exits the Fund prior to June 30, the provider shall be entitled to a refund of one-twelfth the annual fee for that class for each full month between the date of exit and the next June 30.

(d) The effective date of the proof of financial responsibility required under s. 655.23 (2), Stats., as it applies to each individual health care provider, shall determine the date of entry to the Fund. The cancellation or withdrawal of such proof shall establish the date of exit.

(5) EFFECTIVE DATE AND EXPIRATION DATE OF FEE SCHEDULES. The effective date of the fee schedule contained in this section shall be the current July 1 and shall expire the next subsequent June 30.

(6) FEE SCHEDULE. The following fee schedule shall be effective from July 1, 1981 to June 30, 1982.

(a) For physicians and surgeons

Class 1	$ 223.00
Class 2	403.00
Class 3	690.00
Class 4	918.00
Class 5	1150.00
Class 6	1380.00
Class 7	1840.00
Class 8	113.00

(b) For resident physicians and surgeons (or fellowships)

Class 1	$ 133.00
Class 2	242.00
Class 3	414.00
Class 4	550.00
Class 5	690.00
Class 6	835.00
Class 7	1104.00

(c) For resident physicians and surgeons (practice outside residency or fellowship)

All classes	$ 173.00