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

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

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

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

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

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

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

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

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

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

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

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

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

(j) "Mortgage guaranty insurers report of policyholders position" means the annual supplementary report required by s. Ins 7.01 (24) (t).

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

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

you have Medicare and want more insurance, a comprehensive Medicare supplement policy is what you need.

Low income people who are Medicaid recipients don't need any more insurance. If you think you might qualify, contact your local social service agency.

Duplicate Coverage is Expensive and Unnecessary. Buy basic coverage first. 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.

Ins 3.48 Preferred provider plans. (1) SCOPE. This section applies to all preferred provider plans as defined in s. 628.36 (2a) (a) 1., Stats.

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

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

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

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

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

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

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

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

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

(4) SUBSTANTIALLY EQUIVALENT BENEFITS DEFINED. (a) For purposes of s. 628.36 (2a) (d), Stats., plans will be considered to provide substantially equivalent benefits if they offer comparable coverage for the following services: hospital room and board, other inpatient hospital services, surgery, home and office physician services, inhospital physician care, x-ray and laboratory services.

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

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

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

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

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

(6) NONPREFERRED PROVIDERS. A preferred provider plan may require that, if a person enrolled in the plan receives health care services from providers not selected by the plan, the person shall pay, in addition to any applicable premium and deductible, an additional portion of the total payment to be made to the providers. The sum of these additional amounts may not be more than $2,500 per year for individual coverage nor more than $5,000 per year for family coverage.

(7) SEVERABILITY. If any provisions 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.

History: Cr. Register, June, 1984, No. 342, eff. 7-1-84.