placed Register October, 1984, No. 346

Chapter Ins 3

CASUALTY INSURANCE

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

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

32. While or as a result of participating in professional athletics.

33. While or as a result of participating in certain specified sports.

34. While or as a result of serving as a volunteer fireman or in other hazardous occupations.

35. Riot or while participating in a riot.

36. Ptomaine poisoning.

37. Gas or poisonous vapor.

38. Sunstroke or heat prostration.

39. Freezing.

40. Poison ivy or fungus infection.

41. Requirement of permanent disability.

42. Reduction because of other insurance.

(k) The following are examples of exceptions, reductions and limitations which generally *do not* affect the basic policy provisions to such an extent that their absence would cause the advertisement to have the capacity and tendency to mislead or deceive.

1. Suicide or attempted suicide, while sane or insane.

2. Intentional self-inflicted injury.

3. Territorial restriction with no limitation of coverage while in United States and Canada.

4. Aviation exclusion under which passage on commercial airlines is covered.

5. Felony or illegal occupation.

6. All uniform individual policy provisions, both required and optional, other than those relating to other insurance.

7. Requirement for regular care by a physician.

8. Definition of total disability.

9. Definition of partial disability.

10. Definition of hospital.

11. Definition of specific total loss.

12. Definition of injury.

13. Definition of physician or surgeon.

14. Definition of nurse.

15. Definition of recurrent disability.

16. Definition of commercial air travel.

17. Provision that hernia will be considered a sickness.

18. Rest Cure.

19. Diagnosis.

20. Prosthetics.

21. Cosmetic surgery exclusion under which such surgery which results from injury is covered.

22. Dental treatment, surgery or procedures exclusion under which such treatment which results from injury to sound natural teeth is covered.

23. Bacterial infection exclusion under which pyogenic infection which results from injury is covered.

24. Eye examination for fitting of glasses.

25. Hearing aid.

26. Exclusion of sickness or disease in a policy providing only accident coverage.

27. Exclusion for miscarriage in policy providing only accident coverage.

(11) RENEWABILITY, CANCELLABILITY AND TERMINATION. An advertisement shall disclose, as required below, the provisions relating to renewability, cancellability and termination and any modification of benefits, losses covered or premiums because of age or for other reasons, in a manner which shall not minimize or render obscure the qualifying conditions.

(a) Any advertisement which refers to renewability, cancellability or termination of a policy shall be subject to the disclosure requirements of this subsection.

(b) An advertisement which refers to a policy benefit and which is an invitation to apply shall be subject to the disclosure requirements of this subsection.

(c) An advertisement which refers to a policy benefit and which is an invitation to inquire shall not be subject to the disclosure requirements of this subsection unless:

1. Paragraph (a) or (f) applies or

2. Such an advertisement mentions benefits, benefit periods or premiums for the purpose of doing more than identifying the policy.

(d) A booklet, summary or explanation of coverage issued to insured persons shall be subject to the disclosure requirements of this subsection.

(e) An advertisement which refers to a policy benefit and which is an institutional advertisement shall not be subject to the disclosure requirements of this subsection unless paragraph (a) or (f) applies.

(f) An advertisement which states or illustrates time or age in connection with eligibility of applicants or continuation of the policy and which implies permanency shall be subject to the disclosure requirements of this subsection.

(28) INSURER'S ADVERTISING FILE. Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its policies hereafter disseminated in this or any other state, whether or not licensed in such other state. With respect to group, blanket and franchise policies, all proposals prepared on the same printed form need not be included in the file; only typical examples of such proposals need be included. A notation shall be attached to each such advertisement in the file indicating the manner and extent of distribution and the form number of any policy, amendment, rider, or endorsement form advertised. A copy of the policy advertised, together with any amendment, rider or endorsement applicable thereto, shall be included in the file with each such advertisement. Such file shall be subject to regular and periodic inspection by the office of the commissioner of insurance. All such advertisements shall be maintained in such file for a period of 4 years or until the filing of the next regular examination report on the insurer, whichever is the longer period.

(29) PENALTY. Violations of this rule shall subject the violator to s. 601.64, Stats.

(30) SEVERABILITY. The provisions of this rule are severable. If any provision of this rule is invalid, or if the application of the rule to any person or circumstance is invalid, such invalidity shall not affect other provisions or applications which can be given effect without the invalid provision or application.

(31) EFFECTIVE DATE. This rule shall apply to all advertisements used in this state after June 1, 1973.

History: Cr. Register, April, 1973, No. 208, eff. 6-1-73; am. (zb), (11) (c) 1. and (11) (e), Register, August, 1973, No.212, eff. 9-1-73; am. (5) (b) 1, Register, April, 1975, No. 232, eff. 5-1-75; emerg. am. (1), (2), (5) (c) and (m) 1, eff. 6-22-76; am. (1), (2), (5) (c) and (m) 1, Register, September, 1976, No. 249, eff. 10-1-76; cr. (9) (zh), Register, November, 1976, No. 251, eff. 12-1-76; am. (2), Register, March, 1979, No. 279, eff. 4-1-79; r. (29), Register, March, 1981, No. 303, eff. 4-1-81.

Ins 3.28 Solicitation, underwriting and claims practices in individual and franchise accident and sickness insurance. (1) PURPOSE. The purpose of this rule is to promote the fair and equitable treatment of Wisconsin residents in the solicitation, underwriting and administration of accident and sickness insurance and of contracts issued by a plan subject to ch. 613, Stats. Sections of Stats. interpreted or implemented by this rule include but are not limited to ss. 601.04 (3), 601.01 (3) (b) 2., 611.20, 618.12 (1), and 632.76, Stats.

(2) SCOPE. This rule applies to the solicitation, underwriting and administration of any insurance issued by any insurer or fraternal benefit society under s. Ins 6.75 (1) (c) or (2) (c) and ss. 600.03 (35) (d) and 632.93, Stats., except credit accident and sickness insurance under s. Ins 6.75 (1) (c) 1. or (2) (c) 1., and to any contract, other than one issued on a group or group type basis as defined in s. Ins 6.51 (3), issued by a plan subject to ch. 613, Stats. For the purpose of this rule, references to insurer, policy, and insurance agent or representative, also apply to organizations or associations operating non-profit plans, contracts, and persons within the scope of the rule, respectively.

(3) APPLICATION FORM. An application form which becomes part of the insurance contract shall provide to the effect that statements made by the applicant in the application form regarding the general medical history or general health of a proposed insured person which require an

opinion or the exercise of judgment are representations or are to the best of the applicant's knowledge and/or belief. Such form need not so provide with respect to statements regarding specifically named diseases, physical conditions, or types of medical consultation or treatment. Such form shall not require the applicant to state that he has not withheld any information or concealed any facts in completing the application; however, the applicant may be required to state that his answers are true and complete to the best of his knowledge and/or belief.

(4) SOLICITATION. An insurance agent or representative shall review carefully with the applicant all questions contained in each application which he prepares and shall set down in each such form all material information disclosed to him by the applicant in response to the questions in such form.

(5) UNDERWRITING (a) An insurer shall make provision for adequate underwriting personnel and procedures so as to process without undue delay each application for insurance received by it.

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

(c) An insurer which issues coverage for a person shall not use the statements, information or material set out in subds. 1, 2 and 3 to void the coverge on the basis of misrepresentation in the application, or deny a claim on the basis of a pre-existing condition defense, unless the insurer has:

1. Resolved patently conflicting or incomplete statements in the application for the coverage;

2. Duly considered information furnished to it:

a. In connection with the processing of such application, or

b. In connection with individual coverage on the person previously issued by it and currently in force, or

3. Duly considered the material which it would have obtained through reasonable inquiry following due consideration of the statements or information.

(d) An insurer shall at the issuance or amendment of a policy, contract or subscriber certificate, furnish notice concerning statements in the application to the policyholder, contracting party or certificate holder, where the application for the coverage or amended coverage contains questions relating to the medical history or other matters concerning the insurability of the person or persons being insured and the application is part of the insurance contract.

1. The notice shall be printed prominently in contrasting color on the first page of the policy, contract, or subscriber certificate or in the form of a sticker, letter or other form attached to the first page of the policy, contract or certificate, or a letter or other form to be mailed within 10 days after the issuance or amendment of coverage.

2. The notice shall contain substantially the following as to text and caption or title:

(d) "Medicare supplement coverage" means coverage which meets the definition in s. 600.03 (35) (e), Stats., as interpreted by sub. (2) (a), and which conforms to subs. (4), (5), and (6).

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

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

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

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

(i) Terms such as "skilled nursing facility" and "benefit period" used in this section shall be as defined by Medicare.

(4) MEDICARE SUPPLEMENT POLICY OR CERTIFICATE REQUIREMENTS. No disability insurance policy or certificate comprehended by this section shall relate its coverage to Medicare or be structured, advertised, or marketed as a supplement to Medicare unless:

(a) The policy or certificate:

1. Provides at a minimum the coverage set out in sub. (5) and applicable statutes, and contains no exclusions or limitations other than those permitted by sub. (6);

2. Contains no pre-existing condition waiting period longer than six months, and does not define a pre-existing condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage;

3. Contains no definitions of terms such as "skilled nursing facility", "hospital", "nurse", "physician", "Medicare eligible expenses", or "benefit period" which are worded less favorably to the insured person than the corresponding Medicare definition, and contains as a definition of the term, "Medicare", "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended", "Title I, Part I of Public Law 39-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import;

4. Does not indemnify against losses resulting from sickness on a different basis from losses resulting from accident;

5. Does not if the policy or certificate is "noncancellable", "guaranteed renewable", or "noncancellable and guaranteed renewable", provide for termination of coverage of a spouse solely because of an event specified for termination of coverage of the insured, other than the nonpayment of premium;

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

certificate was in force, although the extension of benefits may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits;

7. Contains a renewal, continuation, or nonrenewal provision, on the first page of the policy or certificate, which satisfies the requirements of s. Ins 3.13 (2) (c), (d) and (e), and clearly states the duration of the term of coverage for which the policy or certificate is issued and for which it may be renewed;

8. Provides that benefits designed to cover cost sharing amounts under Medicare shall be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors, although there may be a corresponding modification of premiums in accordance with the policy provisions and ch. 625, Stats., and;

9. Is approved by the commissioner.

(b) The policy in the case of an individual policy, or the certificate in the case of a group policy:

1. Contains in close conjunction on its first page the designation, printed in 18-point type of a style in general use, and the caption, printed in 12-point type of a style in general use, prescribed in sub. (5); and

2. 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.

(c) The outline of coverage for the policy or certificate:

1. Is provided to all applicants at the time application is made and, except in the case of direct response insurance, the insurer obtains written acknowledgement from the applicant that the outline was received;

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

3. Is substituted so as to properly describe the policy or certificate when it is issued, if the outline provided at the time of application does not properly describe the coverage which was issued, and the substituted outline accompanies the policy or certificate when it is delivered and contains the following statement, in no less than 12-point type, immediatley above the company name: "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued.";

4. Contains in close conjunction on its first page the designation, printed in a distinctly contrasting color in 24-point type of a style in general use, and the caption, printed in a distinctly contrasting color in 18-point type of a style in general use, prescribed in sub. (5);

5. Is in the format prescribed in the appendix to this section;

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

7. Is approved by the commissioner along with the policy or certificate form.

(d) Any rider or endorsement added to the policy or certificate:

1. Shall be set forth in the policy or certificate and, if a separate, additional premium is charged in connection with the rider or endorsement the premium charge shall be set forth in the policy or certificate; and

2. After the date of policy or certificate issue, shall be agreed to in writing signed by the insured, if the rider or endorsement increases benefits or coverage with an accompanying increase in premium during the term of the policy or certificate, unless the increase in benefits or coverage is required by law.

(e) The anticipated loss ratio for the policy form, that is, the expected percentage of the aggregate amount of premiums collected which will be returned to insureds in the form of aggregate benefits under the policy form:

1. Is computed on the basis of anticipated incurred claims and earned premiums as estimated for the entire period for which rates are computed to provide coverage, in accordance with accepted actuarial principles and practices;

2. Is at least 60% in the case of individual policies;

3. Is at least 60% in the case of group policies issued as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising;

4. Is at least 75% in the case of group policies other than those described in subd. 3; and

5. Is approved by the commissioner along with the policy form.

(5) AUTHORIZED MEDICARE SUPPLEMENT POLICY OR CERTIFICATE DESIGNATIONS, CAPTIONS, AND MINIMUM COVERAGES. For a policy or certificate to meet the requirements of sub. (4), it shall 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 or certificate shall include:

1. The following designation: MEDICARE SUPPLEMENT 1

2. The following caption, except that the word "certificate" may be used in the last two sentences instead of "policy", if appropriate: The Wisconsin Insurance Commissioner has set minimum standards for Medicare supplement policies. There are three types. A Medicare supplement 1 offers the most protection. A Medicare supplement 3 offers the least protection. For an explanation, see "Health Insurance Advice for Senior Citizens," given to you when you applied for this policy. Do not buy this policy if you did not get this guide.

3. The following minimum coverage: This level of coverage shall at a minimum cover all expenses listed below.

a. Medicare Part A eligible expenses for hospitalization, including inpatient psychiatric care, to the extent not covered by Medicare from the 61st through the 90th day in any Medicare benefit period;

b. Medicare Part A eligible expenses for hospitalization, including inpatient psychiatric care, to the extent not covered by Medicare during use of Medicare's lifetime hospital inpatient reserve days;

c. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days or the maximum coverage for inpatient psychiatric care, all Medicare Part A eligible expenses for hospitalization not covered by Medicare, including inpatient psychiatric care, subject to a maximum benefit of at least an additional 365 days per Medicare benefit period;

d. Medicare Part A eligible expenses for extended care services in a skilled nursing facility to the extent not covered by Medicare subject to a maximum benefit per Medicare benefit period of at least 365 days;

e. All Medicare Part A eligible expenses for blood to the extent not covered by Medicare;

f. All usual and customary charges for Medicare Part B eligible expenses, except outpatient psychiatric care, to the extent not covered by Medicare regardless of hospital confinement, based upon the insurer's determination of usual and customary charges in the area in which the expenses are incurred, subject to a minimum benefit of at least $7,500 per calendar year;

g. At least 75% of usual and customary charges for prescription drugs based upon the insurer's determination of usual and customary charges in the area in which the expenses are incurred, subject to the $7,500 calendar year maximum benefit for Medicare Part B eligible expenses; and

h. At least 50% of usual and customary charges for outpatient psychiatric treatment expenses, based upon the insurer's determination of usual and customary charges in the area in which the expenses are incurred, up to a lifetime maximum of at least $1,000 which may be applied to the $7,500 calendar year maximum benefit for Medicare Part B eligible expenses.

(b) A MEDICARE SUPPLEMENT 2 policy or certificate shall include:

1. The following designation: MEDICARE SUPPLEMENT 2

2. The following caption, except that the word "certificate" may be used in the last two sentences instead of "policy", if appropriate: The Wisconsin Insurance Commissioner has set minimum standards for Medicare supplement policies. There are three types. A Medicare supplement 1 offers the most protection. A Medicare supplement 3 offers the least protection. For an explanation, see "Health Insurance Advice for Senior Citizens," given to you when you applied for this policy. Do not buy this policy if you did not get this guide.

3. The following minimum coverage: This level of coverage shall at a minimum cover all Medicare eligible expenses listed below.

a. Medicare Part A eligible expenses for hospitalization, including inpatient psychiatric care, to the extent not covered by Medicare from the 61st through the 90th day in any Medicare benefit period;

b. Medicare Part A eligible expenses for hospitalization, including inpatient psychiatric care, to the extent not covered by Medicare during use of Medicare's lifetime hospital inpatient reserve days;

c. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days or the maximum coverage for inpatient psychiatric care, all Medicare Part A eligible expenses for hospitalization not covered by Medicare, including inpatient psychiatric care, subject to a lifetime maximum benefit of at least an additional 365 days;

d. Medicare Part A eligible expenses for extended care services in a skilled nursing facility to the extent not covered by Medicare subject to a maximum benefit per Medicare benefit period of at least 365 days; and

e. All Medicare Part B eligible expenses, except outpatient psychiatric care, to the extent not covered by Medicare regardless of hospital confinement, subject to a maximum benefit of at least $5,000 per calendar year.

(c) A MEDICARE SUPPLEMENT 3 policy or certificate shall include:

1. The following designation: MEDICARE SUPPLEMENT 3

2. The following caption, except that the word "certificate" may be used in the last two sentences instead of "policy", if appropriate: The Wisconsin Insurance Commissioner has set minimum standards for Medicare supplement policies. There are three types. A Medicare supplement 1 offers the most protection. A Medicare supplement 3 offers the least protection. For an explanation, see "Health Insurance Advice for Senior Citizens," given to you when you applied for this policy. Do not buy this policy if you did not get this guide.

3. The following minimum coverage: This level of coverage shall at a minimum cover all Medicare eligible expenses listed below.

a. Medicare Part A eligible expenses for hospitalization, excluding inpatient psychiatric care, to the extent not covered by Medicare from the 61st through the 90th day in any Medicare benefit period;

b. Medicare Part A eligible expenses for hospitalization, excluding inpatient psychiatric care, to the extent not covered by Medicare during use of Medicare's lifetime hospital inpatient reserve days;

c. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, at least 90% of all Medicare Part A eligible expenses for hospitalization not covered by Medicare, excluding inpatient psychiatric care, subject to a lifetime maximum benefit of at least an additional 365 days; and

d. At least 20% of all Medicare Part B eligible expenses, except outpatient psychiatric care, regardless of hospital confinement, subject to a maximum calendar year out-of-pocket deductible of $200 of such expenses and to a maximum benefit of at least $5,000 per calendar year.

(6) PERMISSIBLE MEDICARE SUPPLEMENT POLICY OR CERTIFICATE EXCLUSIONS AND LIMITATIONS. (a) The coverage set out in sub. (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 Medicare supplements 1 and 2 shall cover inhospital treatment of mental illness the same as any other illness;

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

5. Contain a pre-existing condition waiting period provision as provided in sub. (4) (a) 2., which shall appear as a separate paragraph of the policy and shall be captioned or titled "Pre-existing Condition Limitations"; and

6. If issued by a voluntary nonprofit sickness care plan subject to ch. 185, Stats., include territorial limitations which are generally applicable to all coverage issued by the plan.

(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 eligible expenses incurred beyond what Medicare Part B would cover may not be excluded.

(c) The coverages set out in sub. (5) may not exclude, limit, or reduce coverage for specifically named or described pre-existing diseases or physical conditions, except as provided in par. (a) 5.

(d) A policy or certificate subject to sub. (5) which provides benefits for "usual", "reasonable", or "customary" charges, or charges described in similar terms, shall contain a definition of the terms and its outline of coverage shall explain the terms.

(7) INDIVIDUAL POLICIES PROVIDING NURSING HOME, HOSPITAL CONFINEMENT INDEMNITY, SPECIFIED DISEASE AND OTHER COVERAGES. (a) *Caption requirements.* Captions required by this subsection shall be:

1. Printed and conspicuously placed on the first page of the Outline of Coverage,

2. Printed on a separate form attached to the first page of the policy, and

3. Printed in 18-point bold letters.

(b) *Nursing home coverage.* An individual policy form providing nursing home coverage subject to s. Ins 3.46 which is sold to a Medicare-eligible persons shall bear the following caption: This policy's nursing home benefits are not related to Medicare. For more information, see "Health Insurance Advice for Senior Citizens", given to you when you applied for this policy.

(c) *Hospital confinement indemnity coverage.* An individual policy form providing hospital confinement indemnity coverage sold to a Medicare eligible person:

1. Shall not include benefits for nursing home confinement unless the nursing home coverage meets the standards set forth in s. Ins 3.46; and

2. Shall bear the following caption, if the policy provides no other types of coverage: This policy is not designed to fill the gaps in Medicare. It will pay you only a fixed dollar amount per day when you are confined to a hospital. For more information, see "Health Insurance Advice for Senior Citizens", given to you when you applied for this policy.

3. Shall bear the caption set forth in par. (e), if the policy provides other types of coverage in addition to the hospital confinement indemnity coverage.

(d) *Specified disease coverage.* An individual policy form providing benefits only for one or more specified diseases sold to a Medicare eligible person shall bear:

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

2. The following caption: This policy covers only one or more specified or rare illnesses. It is not a substitute for a broader policy which would generally cover any illness or injury. For more information, see "Health Insurance Advice for Senior Citizens", given to you when you applied for this policy.

(e) *Other coverage.* An individual disability policy sold to a Medicare eligible person, other than a form subject to sub. (5) or otherwise subject to the caption requirements in this subsection or exempted by sub. (2) (d) or (e), shall bear the following caption: This policy is not a Medicare supplement. For more information, see "Health Insurance Advice for Senior Citizens", given to you when you applied for this policy.

(f) *Use of terms.* Except as otherwise provided in this subsection, the terms "Medicare Supplement", "Medigap" and words of similar import shall not be used in a policy or in any advertisement or sales presentation for a policy, unless the policy conforms to sub. (4).

(8) CONVERSION OR CONTINUATION OF COVERAGE. (a) *Conversion requirements.* An insured under individual, family, or group hospital or medical coverage who will become eligible for Medicare and is offered a conversion policy which is not subject to subs. (4), (5), and (6) shall be furnished by the insurer, at the time the conversion application is furnished in the case of individual or family coverage or within 14 days of a request in the case of group coverage:

1. An outline of coverage as described in par. (d) and

2. A copy of the current edition of the pamphlet described in sub. (9).

(b) *Continuation requirements.* An insured under individual, family, or group hospital or medical coverage who will become eligible for Medicare and whose coverage will continue with changed benefits (e.g., "carve-out" or reduced benefits) shall be furnished by the insurer, within 14 days of a request:

1. A comprehensive written explanation of the coverage to be provided after Medicare eligibility, and

2. A copy of the current edition of the pamphlet described in sub. (9).

(c) *Notice to group policyholder.* An insurer which provides group hospital or medical coverage shall furnish to each group policyholder:

1. Annual written notice of the availability of the materials described in pars. (a) and (b), where applicable, and

2. Within 14 days of a request, sufficient copies of the same or a similar notice to be distributed to the group members affected.

(d) *Outline of coverage.* The outline of coverage:

1. For a conversion policy which relates its benefits to or complements Medicare, shall comply with sub. (4) (c) 2., 5. and 6. of this section and shall be submitted to the commissioner; and

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

(9) "Health insurance advice for senior citizens" pamphlet. Every prospective Medicare eligible purchaser of any policy or certificate subject to this section which provides hospital or medical coverage, other than incidentally, or of any coverage added to an existing Medicare supplement policy or certificate 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 s. Ins 3.27 (5) (g). Except in the case of direct response insurance, written acknowledgement of receipt of this pamphlet shall be obtained by the insurer. This pamphlet 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 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 or certificate in accordance with this section, that authorization is not to be construed or advertised as a recommendation of any particular policy or certificate by the commissioner or the state of Wisconsin.

(11) EXEMPTION OF CERTAIN POLICIES AND CERTIFICATES FROM CERTAIN STATUTORY MEDICARE SUPPLEMENT REQUIREMENTS. Policies and certificates described in sub. (2) (d) of this section, even if they are Medicare supplement policies as defined in s. 600.03 (35) (e), Stats., shall not be subject to:

(a) The special right of return provision for Medicare supplement policies set forth in s. 632.73 (2m), Stats., and s. Ins 3.13 (2) (j) 3.; and

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

(12) 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.

(13) EFFECTIVE DATE. This section was orginally adopted in 1977 and was amended in 1978 and 1981. The requirements contained in or applications of the earlier versions which were not subsequently repealed continue to apply. The requirements or applications included in this revision apply to policies issued on or after July 1, 1982, except that the requirements or applications included in subs. (8) and (11) of this section apply to policies issued or renewed on or after July 1, 1982.

APPENDIX

(COMPANY NAME)

OUTLINE OF MEDICARE

SUPPLEMENT COVERAGE

(The designation and caption required by sub. (4) (c) 4.)

(1) Read Your Policy Carefully — This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) Medicare Supplement Coverage — Policies of this category are designed to supplement Medicare by covering some hospital, medical, and surgical services which are partially covered by Medicare. Coverage is provided for hospital inpatient charges and some physician charges, subject to any deductibles and co-payment provisions which may be in addition to those provided by Medicare, and subject to other limitations which may be set forth in the policy. 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 (delete if such coverage is provided).

(3) (a) (for intermediaries:)

Neither (insert company's name) nor its agents are connected with Medicare.

(b) (for direct responses:)

(insert company's name) is not connected with Medicare.

(4) (A brief summary of the major benefit gaps in Medicare Parts A and B with a parallel description of supplemental benefits, including dollar amounts, provided by the Medicare supplement coverage in the following order:)

SERVICE	BENEFIT	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
HOSPITALIZATION . . . semiprivate room and board, general nursing and miscellaneous hospital services and supplies	First 60 days	All but $(260)		
	61st to 90th day	All but $(65) a day		
Includes meals, special care units, drugs, lab tests, diagnostic x-rays, medical supplies, operating and recovery room, anesthesia and rehabilitation services	91st to 150th day	All but $(130) a day		
	Beyond 150 days	Nothing		
POSTHOSPITAL SKILLED NURSING CARE . . .In a facility approved by Medicare, you must have been in a hospital for at least three days and enter the facility within 30 days after hospital discharge.	First 20 days	100% of costs		
	Additional 80 days	All but $(32.50) a day		
	Beyond 100 days	Nothing		
MEDICAL EXPENSE	Physician's services, inpatient and outpatient medical services and supplies at a hospital, physical and speech therapy and ambulance.	80% of reasonable charge [after $(75) deductible]		

(5) (Statement that the policy does or does not cover the following:)

(a) Private duty nursing,

(b) Skilled nursing home care costs (beyond what is covered by Medicare),

(c) Custodial nursing home care costs,

(d) Intermediate nursing home care costs,

(e) Home health care above number of visits covered by Medicare,

(f) Physician charges (above Medicare's reasonable charge),

(g) Drugs (other than prescription drugs furnished during a hospital or skilled nursing facility stay),

(h) Care received outside of U.S.A.,

(i) Dental care of dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for the cost of eyeglasses or hearing aids.

(6) (A description of any policy provisions which exclude, eliminate, resist, reduce, limit, delay, or in any other manner operate to qualify payments of the benefits described in (4) above, including conspicuous statements:)

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

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

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

(8) (The amount of premium for this policy.)

Drafting Note: The term "certificate" should be substituted for the word "policy" throughout the outline of coverage where appropriate. The outline is subject to s. Ins 3.27 (5) (1) and (9) (u), (v) and (zh) 2. and 4.

History: Cr. Register, July, 1977, No. 259, eff. 11-29-77; am. (13), Register, September, 1977, No. 261, eff. 1-1-78; am. (2), (3) (d), (4) (a) 1., (4) (b) 1. a., 3. e. and 4., (5) (a) 3. a., (5) (b) 3. intro., 3. a., 3. b., (5) (c) 3. a. and b., (5) (d) 3. a., (5) (e) 3. intro. and a., r. and recr. (4) (b) 5., (6), (7), (8) and (9), r. (10), renum. (11) to (13) to be (10) to (12), cr. (4) (b) 6. and 7., Register, December, 1978, No. 276, eff. 1-1-79; am. (4) (b) 1.a., (5) (a) 2. and (b) 2., (5) (c) 2. and (9), r. (5) (d) and (e), Register, April, 1981, No. 304, eff. 5-1-81; r. and recr. (7) (b), Register, May, 1981, No. 305, eff. 6-1-81; r. and recr. Register, June, 1982, No. 318, eff. 7-1-82.

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

(2) SCOPE. This section applies to all group and blanket disability insurance policies subject to s. 631.01 (1), Stats., providing 24-hour cover-

age 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.

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