being paid other depositors on similar deposits with such bank or other financial institution. This shall not be construed to prohibit the maintenance by an insurer of such demand deposits as are reasonable necessary for use in the ordinary course of business of the insurer.

(d) The offer to sell or the sale of any capital stock or other security or certificate of indebtedness of the insurer or affiliated person.

(e) The offer to pay or the payment of any part of the premium for any insurance on the life, health or property of any creditor or any employe or other person affiliated with the creditor.

(f) The extension to the creditor of credit for the remittance of premium beyond the grace period of a group policy or for more than 45 days from the effective date of an individual policy.

(4) PENALTY. Violations of this rule shall subject the insurer or agent to s. 601.64, Stats.

History: Cr. Register, October, 1972, No. 202, eff. 11-1-72; emerg. am. (1) and (2), eff. 6-22-76; am. (1) and (2), Register, September, 1976, No. 249, eff. 10-1-76; am. (1) and (2), Register, March, 1979, No. 279, eff. 4-1-79.

**Ins 3.27 Advertisements of and deceptive practices in accident and sickness insurance.** (1) PURPOSE. The interest of prospective purchasers of accident and sickness insurance must be safeguarded by providing such persons with clear and unambiguous statements, explanations, advertisements and written proposals concerning the policies offered to them. This purpose can best be achieved by the establishment of and adherence to certain minimum standards of and guidelines for conduct in the advertising and sale of such insurance which prevent unfair competition among insurers and are conducive to the accurate presentation and description to the insurance buying public of policies of such insurance. This rule interprets and implements, including but not limited to, the following Wisconsin Statutes: ss. 628.34 and 601.01 (3).

(2) SCOPE. This rule shall apply to any solicitation, representation or advertisement in this state of any insurance specified in s. Ins 6.75 (1) (c) or (2) (c), made directly or indirectly by or on behalf of any insurer, fraternal benefit society, nonprofit service plan subject to ch. 613, Stats., voluntary nonprofit sickness care plan organized under s. 185.981, Stats., interscholastic benefit plan organized under s. 185.991, Stats., or agent as defined in ch. 628, Stats.

(3) INTERPRETATION OF REQUIREMENTS APPLICABLE TO ADVERTISEMENTS. (a) The proper promotion, sale and expansion of accident and sickness insurance are in the public interest. This rule is to be construed in a manner which does not unduly restrict, inhibit or retard such promotion, sale and expansion.

(b) In applying this rule, it shall be recognized that advertising is essential in promoting a broader distribution of accident and sickness insurance. Advertising necessarily seeks to serve this purpose in various ways. Some advertisements are the direct or principal sales inducement and are designed to invite offers to contract. In other advertisements the function is to describe coverage broadly for the purpose of inviting inquiry for further information.Other advertisements are for the purpose of summarizing or explaning coverage after the sale has been made. Still other advertisements are solely for the purpose of promoting the interest of the reader in the concept of accident and sickness insurance or of pro-

moting the insurer sponsoring the advertisement. These differences shall be considered in interpreting this rule.

(c) When applying this rule to a specific advertisement, the type of policy to which the advertisement refers and the detail, character, purpose, use and entire content of the advertisement shall be taken into consideration.

(d) This rule applies to individual, franchise, group and blanket accident and sickness insurance. Because these types of coverage differ in some respects, one interpretation will not always suffice; a specific interpretation for individual, franchise, group or blanket coverage may be indicated.

(e) The extent to which policy provisions need be disclosed in an advertisement will depend on the content, detail, character, purpose and use of the advertisement and the nature of the exceptions, reductions, limitations and other qualifications involved. The principal criterion is whether the advertisement has the capacity and tendency to mislead or deceive if such a provision is not disclosed.

(f) Whether an advertisement has the capacity and tendency to mislead or deceive shall be determined by the commissioner from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence within the segment of the public to which it is directed.

(4) COVERAGE TYPES. (a) An advertisement which is an invitation to inquire or an invitation to apply shall clearly and prominently designate and at least briefly describe the type or types of coverage provided by the policy advertised. The level and extent of benefits provided by or available under the coverage shall also be clearly indicated.

(b) The following are the standard types of coverage designations and the minimum adequate form of description that must be used. Any type of coverage authorized by Wisconsin Statutes which is not reasonably included within one or more of the standard coverage types listed shall be similarly and appropriately named and described so as to clearly disclose the benefits provided.

1. Basic hospital expense benefits. This coverage provides benefits for hospital room and board and miscellaneous hospital charges, based upon actual expenses incurred, up to stated maximum amounts.

2. Basic medical expense benefits. This coverage provides benefits for medical benefits based upon actual expenses incurred, up to stated maximum amounts.

3. Basic surgical expense benefits. This coverage provides benefits for surgical benefits based upon actual expenses incurred up to stated maximum amounts.

4. Major medical or comprehensive expense benefits. These coverages provide high maximum benefit amounts covering almost all types of medical care and contain deductible and co-insurance features.

5. Disability income benefits. This coverage provides periodic benefit payments to help replace income when the insured is unable to work as a result of illness or injury.

the insured may select his room expense benefit at the time of hospitalization.

(l) An advertisement shall not imply that the amount of benefits payable under a loss of time policy may be increased at time of disability according to the needs of the insured.

(m) The term "confining sickness" is an abbreviated expression and shall be explained if used in an advertisement.

(n) An advertisement shall not state that the insurer "pays hospital, surgical, medical bills", "pays dollars to offset the cost of medical care", "safeguards your standard of living", "pays full coverage", "pays complete coverage", "pays for financial needs", "provides for replacement of your lost paycheck", "guarantees your paycheck", "guarantees your income", "continues your income", "provides a guaranteed paycheck", "provides a guaranteed income" or "fills the gaps in Medicare" or use similar words or phrases unless the statement is literally true. Where appropriate, such or similar words or phrases may properly be used if preceded by the words "help", "aid", "assist" or similar words.

(o) An advertisement shall not state that the premiums will not be changed in the future unless such is the fact.

(p) An advertisement shall clearly indicate the provisions of any deductible under a policy.

(q) An advertisement shall not refer to a policy as a doctors policy or use words of similar import unless:

1. The advertisement includes a statement that the plan of benefits is not endorsed by or associated with any national, state or local medical society, or

2. The policy has been so endorsed by such a society and the advertisement meets the requirements of sub. (13).

(r) If a policy contains any of the following or similar provisions, an advertisement referring to such policy shall not state that benefits are payable in addition to other insurance unless the statement contains an appropriate reference to the coverage excepted:

1. An other insurance exception, reduction, limitation or deductible

2. A coordination of benefits or non-duplication provision

3. An other insurance in this company provision

4. An insurance in other insurers provision

5. A relation of earnings to insurance provision

6. A workmen's compensation or employers' liability or occupational disease law exception, reduction, or limitation

7. A reduction based on social security benefits or other disability benefits, or

8. A Medicare exception, reduction, or limitation.

(s) An advertisement shall not state a policy's benefits are tax free unless an explanation of the rules applicable to the taxation of such types of

accident and sickness benefits is clearly shown with equal prominence and in close conjunction with such statement. An advertisement of a benefit for which payment is conditioned upon confinement in a hospital or similar facility shall not state that such benefit is tax free.

(t) An advertisement shall not use the expressions "extra cash", "cash income", "income", "cash" or similar words or phrases in such a way as to imply that the insured will receive benefits in excess of his expenses incurred while being sick, injured or hospitalized.

(u) The description in advertisements of government insurance programs, including Medicare, and of changes in such program shall be accurate and not give an incorrect impression as to the need for supplementary coverage. If gaps in such programs are referred to, they shall be described fairly so that the reader or listener can determine how the policy being advertised covers such gaps.

(v) An advertisement which refers to a policy as being a Medicare supplement shall:

1. Contain a prominent statement indicating which Medicare benefits the policy is intended to supplement (for example, hospital benefits) and which Medicare benefits the policy will not supplement (for example, medical-surgical benefits) and shall clearly disclose any gaps in Medicare coverage for which the policy does not provide benefits and

2. Clearly indicate the extent of the benefits if the policy bases benefits on expenses incurred beyond what Medicare covers and thus provides somewhat limited benefits for short term hospital confinements.

(w) An advertisement may refer to immediate coverage or guaranteed issuance of a policy only if suitable administrative procedures exist so that the policy is issued within a reasonable time after the application is received.

(x) If an advertisement indicates an initial premium which differs from the renewal premium on the same mode, the renewal premium shall be disclosed with equal prominence and in close conjunction with any statement of the initial premium. Any increase in premium or reduction in coverage because of age shall be clearly disclosed.

(y) An advertisement shall not state that the policy contains no waiting period unless pre-existing conditions are covered immediately or unless the status of pre-existing conditions is disclosed with equal prominence and in close conjunction with such statement.

(z) An advertisement shall not state that no age limit applies to a policy unless applications from applicants of any age are considered in good faith and such statement clearly indicates the date or age to which the policy may be renewed or that the company may refuse renewal.

(za) An advertisement shall not state that no medical, doctor's or physical examination is required or that no health, medical or doctor's statements or questions are required or that such examination, statements or questions are waived or otherwise state or imply that the applicant's physical condition or medical history will not affect the policy unless:

1. The statement indicates with equal prominence that it applies only to the issuance of the policy or to both the issuance of the policy and the payment of claims, and

2. Pre-existing conditions are covered immediately under the policy or the peiod of time following the effective date of the policy during which pre-existing conditions are not covered is disclosed with equal prominence and in close conjunction with such statement.

(zb) An advertisemt of a limited policy as defined in s. Ins 3.13 (2) (h) shall prominently indicate that the policy provided limited coverage with an appropriate statement such as "THIS IS A CANCER ONLY POLICY" or "THIS IS AN AUTOMOBILE ACCIDENT ONLY POLICY," and shall clearly disclose what injuries or sicknesses and what losses are covered.

(zc) An advertisement of a policy which provides benefits for injuries only or for sickness only shall prominently indicate that the policy covers injuries only or sickness only.

(zd) An advertisement shall not refer to a policy or coverage as being "special" unless it can be shown that there is a reasonable basis for the use of such a term.

(ze) An advertisement shall not set out exceptions, reductions or limitations from a policy worded in a positive manner to imply that they are beneficial features such as describing a waiting period as a benefit builder. Words and phrases used to disclose exceptions, reductions or limitations shall fairly and accurately describe their negative features. The words "only" or "minimum" or similar words or phrases shall not be used to refer to exceptions, reductions or limitations.

(zf) An advertisement shall not state or imply, or use similar words or phrases to the effect, that because no insurance agent will call and no commissions will be paid to agents the policy is a low cost plan.

(zg) Devices such as a safe drivers' award and other such awards shall not be used in connection with an advertisement.

(zh) An advertisement which describes or offers to provide information concerning the federal Medicare program or any related government program or changes in such programs shall:

1. Include no reference to such program on the envelope, the reply envelope or to the address side of the reply postal card, if any,

2. Include on any page containing a reference to such program an equally prominent statement to the effect that in providing supplemental coverage the insurer and agent involved in the solicitation is not in any manner connected with such program,

3. Contain a statement that it is an advertisement for insurance or is intended to obtain insurance prospects,

4. Prominently identify the insurer or insurers which issues the coverage, and

5. Prominently state that any material or information offered will be delivered in person by a representative of the insurer, if such is the case.

(10) EXCEPTIONS, REDUCTIONS AND LIMITATIONS. (a) When an advertisement refers to any dollar amount of benefits payable, period of time for which any benefit is payable, cost of policy, specific policy benefit or the loss for which such benefit is payable, it shall also disclose those exceptions, reductions and limitations (including waiting, elimination, probationary or similar periods and pre-existing condition exceptions) affecting the basic provisions of the policy without which the advertisement would have the capacity and tendency to mislead or deceive subject to the following.

(b) An invitation to apply shall be subject to the disclosure requirements of this subsection.

(c) An invitation to inquire shall not be subject to the disclosure requirements of this subsection unless:

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

2. Such an advertisement makes any reference to the policy's exceptions, reductions and limitations.

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

(e) An institutional advertisement shall not be subject to the disclosure requirements of this subsection.

(f) If the policy advertised does not provide immediate coverage for pre-existing conditions, an application or enrollment form contained in or included with an advertisement to be completed by the applicant and returned to the insurer shall contain a question or statement immediately preceding the applicant's signature line which summarizes the pre-existing condition provisions of the policy. The following are a suggested question and statement; however, an insurer shall use wording which is appropriate to the actual pre-existing condition provisions of the policy advertised: "Do you understand that the policy applied for will not pay benefits during the first - - - - - year(s) after the issue date for a disease or physical condition which you now have or have had in the past? Yes - - - - -" or "I understand that the policy applied for will not pay benefits during the first - - - - - year(s) after the issue date for a disease or physical condition which I now have or have had in the past."

(g) An advertisement which is subject to the disclosure requirements of this subsection shall in negative terms disclose the extent to which any loss is not covered if the cause of the loss is a condition which exists prior to the effective date of the policy. The expression "pre-existing conditions" shall not be used unless appropriately defined.

(h) If a medical examination is required for a policy, an advertisement of such policy shall disclose such requirement.

(i) The exceptions, reductions and limitations referred to in this subsection shall include:

1. Those which are set out in the policy under captions referring to exceptions, reductions, limitations or exclusions or are otherwise designated as such, and

(25) NON-CANCELLABLE AND GUARANTEED RENEWABLE POLICIES. (a)No person, in the presentation, solicitation, effectuation, or sale of a policy, and no advertisement, relating to or used in connection with a policy, shall use the terms "non-cancellable" or "non-cancellable and guaranteed renewable" or "guaranteed renewable", except in connection with policies conforming to s. Ins 3.13 (2) (e).

(b) An advertisement describing a non-cancellable and guaranteed renewable or guaranteed renewable policy form shall be subject to sub. (11).

(c) A printed advertisement describing a non-cancellable or non-cancellable and guaranteed renewable policy form shall disclose, as prominently as and in close conjunction with any prominent use of the terms "non-cancellable" or "non-cancellable and guaranteed renewable":

1. The age to or term for which the form is non-cancellable or non-cancellable and guaranteed renewable, if other than lifetime,

2. The age or time at which the form's benefits are reduced, if applicable, (the age or time at which a form's benefits are reduced need not be so disclosed if such reduction is not effected prior to the age to or term for which the form is non-cancellable or non-cancellable and guaranteed renewable or if regular benefits are payable at least to the age to or term for which the form is non-cancellable or non-cancellable and guaranteed renewable), and

3. That benefit payments are subject to an aggregate limit, if applicable.

(d) A printed advertisement describing a guaranteed renewable policy form shall disclose, as prominently as and in close conjunction with any prominent use of the term "guaranteed renewable":

1. The age to or term for which the form is guaranteed renewable, if other than lifetime,

2. The age or time at which the form's benefits are reduced, if applicable, (the age or time at which a form's benefits are reduced need not be so disclosed if such reduction is not effected prior to the age to or form for which the form is guaranteed renewable or if regular benefits are payable at least to the age to or term for which the form is guaranteed renewable)

3. That benefit payments are subject to an aggregate limit, if applicable, and

4. That the applicable premium rates may be changed.

(e) The foregoing limitations on the use of the term "non-cancellable" shall also apply to any synonymous term such as "not cancellable"; and the foregoing limitations on use of the term "guaranteed renewable" shall apply to any synonymous term such as "guaranteed continuable".

(26) FORM NUMBER. An advertisement which is an invitation to apply or an invitation to inquire and which is mass-produced shall be identified by a form number. The form number shall be sufficient to distinguish it from any other advertising form or any policy, application or other form used by the insurer.

(27) INSURER'S RESPONSIBILITY FOR ADVERTISEMENTS. (a) The content, form and method of dissemination of all advertisements, regardless of by whom designed, created, written, printed or used, shall be the responsibility of the insurer whose policy is advertised.

(b) An insurer shall require its agents and any other person or agency acting on its behalf in preparing advertisements to submit proposed advertisements to it for approval prior to use.

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

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

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

History: Cr. Register, April, 1973, No. 208, eff. 6-1-73; am. (zb), (11) (c) 1. and (11) (e), Register, August, 1973, No.212, eff. 9-1-73; am. (5) (b) 1, Register, April, 1975, No. 232, eff. 5-1-75; emerg. am. (1), (2), (5) (c) and (m) 1, eff. 6-22-76; am. (1), (2), (5) (c) and (m) 1, Register, September, 1976, No. 249, eff. 10-1-76; cr. (9) (zh), Register, November, 1976, No. 251, eff. 12-1-76; am. (2), Register, March, 1979, No. 279, eff. 4-1-79; r. (29), Register, March, 1981, No. 303, eff. 4-1-81; cr. (10) (j) 43, Register, October, 1984, No. 346, eff. 11-1-84; r. (30) under s. 13.93 (2m) (b) 16, Stats., Register, December, 1984, No. 348.

**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.

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

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

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

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

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

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

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

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

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

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

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

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

**Ins 3.44 Effective date of s. 632.897, Stats.** (1) Section 632.897, Stats., applies to group policies issued or renewed on or after May 14, 1980, or if a policy is not renewed within 2 years after the effective date of the act, s. 632.897, Stats., is effective at the end of 2 years from May 14, 1980.

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

(b) A group policy as defined in s. 632.897 (1) (c) 2 shall be considered to have been renewed on any date on which an underlying collective bar-

gaining agreement or other underlying contract is renewed, or on which a significant change is made in benefits.

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

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

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

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

**Ins 3.46 Standards for nursing home insurance.** (1) FINDINGS. Information on file in the office of the commissioner of insurance shows 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, 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.

(c) This section applies to any individual insurance policy issued on or after July 1, 1982 to a person eligible for Medicare by reason of age which provides coverage for confinement or care in a nursing home in addition to providing hospital confinement indemnity coverage as defined in s. Ins 3.27 (4) (b) 6.

(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).

(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.

(6m) 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; cr. (3) (c), Register, June, 1982, No. 318, eff. 7-1-82.

**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.

(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).

(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.