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 3.08 Municipal bond insurance. (1) PURPOSE. This section implements and interprets ss. 601.42, 611.19 (1), 618.21, 623.03, 623.04, 627.05, 628.34 (2), 632.14, and 632.17, Stats., for the purpose of establishing minimum requirements for the transaction of a type of surety insurance known as municipal bond insurance.

(2) SCOPE. This section shall apply to the underwriting, marketing, rating, accounting and reserving activities of insurers which write municipal bond insurance.

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

(b) "Contingency reserve" means a reserve established for the protection of policyholders covered by policies insuring municipal bonds against the effect of excessive losses occurring during adverse economic cycles.

(c) "Cumulative net liability" means one-third of one percent of the insured unpaid principal and insured unpaid interest covered by in-force policies of municipal bond insurance.

(d) "Municipal bonds" means securities which are issued by or on behalf of or are paid or guaranteed by:

1. Any state, territory or possession of the United States of America;

2. Any political subdivision of any such state, territory or possession; or

3. Any agency, authority or corporate or other instrumentality of any one or more of the foregoing, or which are guaranteed by any of the foregoing.

(e) "Municipal bond insurance" means a type of surety insurance authorized by s. Ins 6.75 (2) (g) which is limited to the guaranteeing of the performance and obligations of municipal bonds.

(f) "Municipal bond insurer" means an insurer which issues municipal bond insurance.

(g) "Total net liability" means the average annual amount due, net of reinsurance, for principal and interest on the insured amount of any one issue of municipal bonds.

(h) "Person" means any individual, corporation for profit or not for profit, association, partnership or any other legal entity.

(i) "Policyholders' surplus" means an insurer's net worth, the difference between its assets and liabilities, as reported in its annual statement.

(4) MINIMUM CAPITAL OR PERMANENT SURPLUS. The minimum capital or permanent surplus of a municipal bond insurer shall be $2 million for an insurer first authorized to do business in Wisconsin on or before Janu-

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chiatric 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.

i. Home care benefits as required under s. 632.895 (1) and (2), Stats., and s. Ins 3.54.

(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 instead of "policy", if appropriate: The Wisconsin Insurance Commissioner has set minimum standards for comprehensive health insurance sold to the Medicare eligible. There are two types—Medicare Supplements and Medicare Replacements. A Medicare Supplement 1 is the most comprehensive Medicare Supplement. A Medicare Supplement 3 is the least comprehensive Medicare Supplement. For an explanation of the minimum benefits for Medicare Supplements and Medicare Replacements and a comparison of the two types 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.

f. Home care benefits as required under s. 632.895 (1) and (2), Stats., and s. Ins 3.54.

(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 instead of "policy", if appropriate: The Wisconsin Insurance Commissioner has set minimum standards for comprehensive health insurance sold to the Medicare eligible. There are two types—Medicare Supplements and Medicare Replacements. A Medicare Supplement 1 is the most comprehensive Medicare Supplement. A Medicare Supplement 3 is the least comprehensive Medicare Supplement. For an explanation of the minimum benefits for Medicare Supplements and Medicare Replacements and a comparison of the two types, 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.

e. Home care benefits as required under s. 632.895 (1) and (2), Stats., and s. Ins 3.54.

(d) A MEDICARE REPLACEMENT policy or certificate shall include:

1. The following designation: MEDICARE REPLACEMENT POLICY;

2. The following caption, except that the word "certificate" may be used instead of "policy", if appropriate: The Wisconsin Insurance Commissioner has set minimum standards for comprehensive health insurance policies sold to the Medicare eligible. There are two types — Medicare supplements and Medicare Replacements. For an explanation of the minimum benefits for Medicare Supplements and Medicare Replacements and a comparison of the two types, 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 in addition to basic Medicare benefits.

a. The initial deductible under Medicare Part A;

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

c. 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;

d. 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;

e. 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

f. The initial deductible under Medicare Part B and all Medicare Part B eligible expenses, except outpatient psychiatric care, to the extent not covered by Medicare regardless of hospital confinement.

g. Home care benefits as required under s. 632.895 (1) and (2), Stats., and s. Ins 3.54.

(6) PERMISSIBLE MEDICARE SUPPLEMENT AND MEDICARE REPLACEMENT 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. Except for Medicare replacement policies under sub. (5) (d), 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 and Medicare replacement policies 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., or a health maintenance organization as defined by s. 628.36 (2m) (a), 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.

(e) Each insurer which markets a Medicare replacement policy shall have an approved MEDICARE SUPPLEMENT 2 available for all currently enrolled participants at such time as the direct risk contract between the Health Care Financing Administration and the insurer is terminated.

(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) (l).

(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 information from the commissioner's office on how to obtain copies 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 been given notice that the revised pamphlet is available.

(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 (28r), Stats., or Medicare replacement policies as defined in s. 600.03 (28p), 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.

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; renum. (4) (a) 9. to be 10., cr. (4) (a) 9., am. (5) (intro.) and (6) (a) 6., Register, October, 1984, No. 346, eff. 11-1-84; r. (12) under s. 13.93 (2m) (b) 16, Stats., Register, December, 1984, No. 348; am. (1) (a) to (c), (2) (a) (intro.), 1. and 2., (3) (b) and (d), (4) (intro.), (a) 5.,8. and 9., (c) 5., (5) (intro.), (a) 2., (b) 2. and (c) 2., (6) (a) 2. and 3., (9), (11) and Appendix, cr. (3) (dm), (5) (d) and (6) (e), r. (13), Register, November, 1985, No. 359, eff. 1-1-86; cr. (5) (a) 3. i., (b) 3. f., (c) 3. e. and (d) 3. g. Register, April, 1987, No. 376, eff. 6-1-87.

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sioner by February 1 each year for the preceding year in a form prescribed by the commissioner.

(11) OTHER NOTICE REQUIREMENTS. Prior to enrolling members, the limited service health organization shall provide to all prospective group or individual policyholders information on the plan, including information on the services covered, a definition of emergency and out-of-area coverage, names and specific location of providers for each type of service, the cost of the plan, enrollment procedures, and limitations on benefits including limitations on choice of providers and the geographical area served by the organization.

(12) DISENROLLMENT. (a) The limited service health organization shall clearly disclose in the policy and certificate any circumstances under which the limited service health organization may disenroll an enrollee.

(b) The limited service health organization may disenroll a member from the limited service health organization for the following reasons only:

1. The policyholder has failed to pay required premiums by the end of the grace period.

2. The enrollee has committed acts of physical or verbal abuse which pose a threat to providers or other members of the organization.

3. The enrollee has allowed a nonmember to use the limited service health organization's membership card or has knowingly provided fraudulent information in applying for coverage with the limited service health organization or in receiving services.

4. The enrollee has moved outside of the geographical service area of the organization.

5. The enrollee is unable to establish or maintain a satisfactory provider-patient relationship with the provider responsible for the enrollee's care. Disenrollment of an enrollee for this reason shall be permitted only if the limited service health organization can demonstrate that it provided the enrollee with the opportunity to select an alternate primary care provider, made a reasonable effort to assist the enrollee in establishing a satisfactory provider-patient relationship and informed the enrollee that he or she may file a grievance on this matter.

(c) A limited service health organization that has disenrolled an enrollee for any reason except failure to pay required premiums shall make arrangements to provide similar insurance coverage to the enrollee. In the case of group certificate holders this insurance coverage shall be continued until the person is able to find similar coverage or until the next opportunity to change insurers, whichever comes first. In the case of an enrollee covered on an individual basis, coverage shall be continued until the anniversary date of the policy or for one year, whichever is earlier.

(13) TIME PERIOD FOR REVIEW. In accordance with s. 227.116, Stats., the commissioner shall review and make a determination on an application for a certificate of authority within 60 business days after it has been received.

(14) Subs. (9), (10), (11) and (12) shall apply to all policies issued or renewed on or after January 1, 1987.

Note: Section Ins 3.51 shall not apply to policies issued or renewed before January 1, 1987.

History: Cr. Register, November, 1986, No. 371, eff. 12-1-86.

Ins 3.54 Home health care benefits under disability insurance policies. (1) PURPOSE. This section implements and interprets ss. 628.34 (1) and (12), 631.20 and 632.895 (1) and (2), Stats., for the purpose of facilitating the administration of claims for coverage of home health care under disability insurance policies and the review of policy forms. The commissioner of insurance shall disapprove a policy under s. 631.20, Stats., if that policy does not meet the minimum requirements specified in this section.

(2) SCOPE. This section applies to disability insurance policies.

(3) DEFINITIONS. In this section:

(a) "Disability insurance policy" means a disability insurance policy as defined under s. 632.895 (1) (a), Stats., which provides coverage of expenses incurred for in-patient hosptial care.

(b) "Home health aide services" means nonmedical services performed by a home health aide which:

1. Are not required to be performed by a registered nurse or licensed practical nurse; and

2. Primarily aid the patient in performing normal activities of daily living.

(c) "Home care visits" means the period of a visit to provide home care, without limit on the duration of the visit, except each consecutive 4 hours in a 24-hour period of home health aide services is one visit.

(d) "Medically necessary" means that the service or supply is:

1. Required to diagnose or treat an injury or sickness and shall be performed or prescribed by the physician;

2. Consistent with the diagnosis and treatment of the sickness or injury;

3. In accordance with generally accepted standards of medical practice; and

4. Not solely for the convenience of the insured or the physician.

(4) MINIMUM REQUIREMENTS. (a) All disability insurance policies including, but not limited to, medicare supplement or replacement policies, shall provide a minimum of 40 home care visits in a consecutive 12-month period for each person covered under the policy and shall make available coverage for supplemental home care visits as required by s. 632.895 (2) (e), Stats.

(b) An insurer shall review each home care claim under a disability insurance policy and may not deny coverage of a home care claim based solely on medicare's denial of benefits.

(c) An insurer may deny coverage of all or a portion of a home health aide service visit because the visit is not medically necessary, not appro-

priately included in the home care plan or not necessary to prevent or postpone confinement in a hospital or skilled nursing facilility only if:

1. The insurer has a reasonable, and documented factual basis for the determination; and

2. The basis for the determination is communicated to the insured in writing.

(d) In determining whether a home care claim, including a claim for home health aide services, is reimbursable under a disability insurance policy, an insurer may apply claim review criteria to determine that home is an appropriate treatment setting for the patient and that it is not reasonable to expect the patient to obtain medically necessary services or supplies on an outpatient basis, subject to the requirements of s. 632.895 (2) (g), Stats.

(e) An insurer shall disclose and clearly define the home care benefits and limitations in a disability insurance policy, certificate and outline of coverage. An insurer may not use the terms "homebound" or "custodial" in the sections of a policy describing home care benefits, exclusions, limitations, or reductions.

(f) In determining whether a home care claim under a disability insurance policy involves medically necessary part-time or intermittent care, an insurer shall give due consideration to the circumstances of each claimant and may not make arbitrary decisions concerning the number of home care visits within a given period which the insurer will reimburse. An insurer may not deny a claim for home care visits without properly reviewing and giving due consideration to the plan of care established by the attending physician under s. 632.895 (1) (b), Stats. An insurer may use claim review criteria based on the number of home care visits in a period for the purpose of determining whether a more thorough review of a home care claim or plan is conducted.

(g) An insurer may use claim review criteria under par. (d) or (f) only if the criteria and review process do not violate s. Ins 6.11. An insurer shall comply with s. 628.34 (1), Stats., when communicating claim review criteria to applicants, insureds, providers or the public.

Note: Section Ins 3.54 applies to disability insurance policies issued or renewed on or after June 1, 1987.

History: Cr. Register, April, 1976, No. 376, eff. 6-1-87.