CHAPTER 632

INSURANCE CONTRACTS IN SPECIFIC LINES

SUBCHAPTER I
FIRE AND OTHER PROPERTY INSURANCE
632.05 Indemnity amounts.
632.07 Prohibiting requiring property insurance in excess of replacement value.
632.08 Mortgage clause.
632.09 Choice of law.
632.10 Definitions applicable to property insurance escrow.
632.101 Policy terms.
632.102 Payment of final settlement.
632.103 Procedure for payment of withheld funds.
632.104 Funds released to mortgagee.
SUBCHAPTER II
SURETY INSURANCE
632.14 Bonds need not be under seal.
632.17 Validity of surety bonds.
632.18 Rustproofing warranties insurance.
632.185 Vehicle protection product warranty insurance policy.
SUBCHAPTER III
LIABILITY INSURANCE IN GENERAL
632.22 Required provisions of liability insurance policies.
632.23 Prohibited exclusions in aircraft insurance policies.
632.24 Direct action against insurer.
632.25 Limited effect of conditions in employer's liability policies.
632.26 Notice provisions.
SUBCHAPTER IV
AUTOMOBILE AND MOTOR VEHICLE INSURANCE
632.32 Provisions of motor vehicle insurance policies.
632.34 Defense of noncooperation.
632.35 Prohibited rejection, cancellation and nonrenewal.
632.36 Accident in the course of business or employment.
632.365 Use of emission inspection data in setting rates.
632.37 Motor vehicle glass repair practices; restriction on specifying vendor.
632.375 Motor vehicle repair practices; restriction on specifying vendor.
632.38 Nonoriginal manufacturer replacement parts.
SUBCHAPTER V
LIFE INSURANCE AND ANNUITIES
632.41 Prohibited provisions in life insurance.
632.415 Funeral policies.
632.42 Trustee and deposit agreements in life insurance.
632.43 Standard nonforfeiture law for life insurance.
632.435 Standard nonforfeiture law for individual deferred annuities.
632.44 Required provisions in life insurance.
632.45 Contracts providing variable benefits.
632.46 Incontestability and misstated age.
632.47 Assignment of life insurance rights.
632.475 Life insurance policy loans.
632.48 Designation of beneficiary.
632.50 Estoppel from medical examination.
632.56 Required group life insurance provisions.
632.57 Conversion option in group and franchise life insurance.
632.60 Limitation on credit life insurance.
632.62 Participating and nonparticipating policies.
632.63 Unclaimed life insurance and annuities.
632.64 Certification of disability.
632.65 Annuities exempt from regulation.
632.66 Annuity contracts without life contingencies.
632.67 Effect of power of attorney for health care.
632.69 Life settlements.
632.695 Applicability of general transfers at death provisions.
632.697 Benefits subject to department's right to recover.
SUBCHAPTER VI
DISABILITY INSURANCE
632.71 Estoppel from medical examination, assignability and change of beneficiary.
632.715 Reports of action against health care provider.
632.72 Medical benefits or assistance; assignment.
632.725 Standardization of health care billing and insurance claim forms.
632.726 Current procedural terminology code changes.
632.729 Prohibiting discrimination based on COVID−19.
632.73 Right to return policy.
632.74 Reinstatement of individual or franchise disability insurance policies.
632.745 Coverage requirements for group and individual health benefit plans; definitions.
632.746 Preexisting condition; portability; restrictions; and special enrollment periods.
632.747 Guaranteed acceptance.
632.748 Prohibiting discrimination.
632.749 Contract termination and renewability.
632.7495 Guaranteed renewability of individual health insurance coverage.
632.7497 Modifications at renewal.
632.75 Prohibited provisions for disability insurance.
632.755 Public assistance and early intervention services.
632.76 Incontestability for disability insurance.
632.77 Permitted provisions for disability insurance policies.
632.775 Effect of power of attorney for health care.
632.78 Required grace period for disability insurance policies.
632.79 Notice of termination of group hospital, surgical or medical expense insurance coverage due to cessation of business or default in payment of premiums.
632.793 Notice of loss of primary insurance coverage due to age.
632.795 Open enrollment upon liquidation.
632.797 Disclosure of group health claims experience.
632.798 Out−of−pocket costs.
632.80 Restrictions on medical payments insurance.
632.81 Minimum standards for certain disability policies.
632.82 Renewability of long−term care insurance policies.
632.825 Midterm termination of long−term care insurance policy by insured.
632.83 Internal grievance procedure.
632.835 Independent review of coverage denial determinations.
632.84 Benefit appeals under certain policies.
632.845 Prohibiting refusal to cover services because liability policy may cover.
632.85 Coverage without prior authorization for treatment of an emergency medical condition.
632.853 Coverage of drugs and devices.
632.855 Requirements if experimental treatment limited.
632.857 Explanation required for restriction or termination of coverage.
632.86 Restrictions on pharmaceutical services.
632.865 Pharmacy benefit managers.
632.866 Step therapy protocols.
632.867 Oral and injected chemotherapy.
632.87 Restrictions on health care services.
632.873 Restrictions relating to fees for dental services.
632.875 Independent evaluations relating to chiropractic treatment.
632.88 Policy extension for handicapped children.
632.885 Coverage of dependents.
632.89 Coverage of mental disorders, alcoholism, and other diseases.
632.895 Mandatory coverage.
632.896 Mandatory coverage of adopted children.
632.897 Hospital and medical coverage for persons insured under individual and group policies.
632.8985 Prohibiting abortion coverage.
632.899 Medical savings accounts study.
SUBCHAPTER VII
FRATERNAL INSURANCE
632.91 Definition.
632.93 The fraternal contract.
632.95 Fraud in obtaining membership.
632.96 Beneficiaries in fraternal contracts.
SUBCHAPTER VIII
MISCELLANEOUS
632.97 Application of proceeds of credit insurance policy.
632.975 Portable electronics insurance.
632.977 Limited lines travel insurance.
632.98 Worker's compensation insurance.
632.99 Certifications of disability.

Cross−reference: See definitions in ss. 600.03 and 628.02.
Cross−reference: See also ch. Ins 3, Wis. adm. code.
NOTE: Chapter 375, laws of 1975, which created subchapters I to VIII of Chapter 632, contains explanatory notes.

SUBCHAPTER I

FIRE AND OTHER PROPERTY INSURANCE

632.05 Indemnity amounts. (1) REPLACEMENT COST OF COVERAGE. An insurer may agree in a property insurance policy to indemnify the insured for the amount it would cost to repair, rebuild or replace the damaged or destroyed insured property with new materials of like size, kind and quality.

(2) TOTAL LOSS. Whenever any policy insures real property that is owned and occupied by the insured primarily as a dwelling and the property is wholly destroyed, without criminal fault on the part of the insured or the insured's assigns, the amount of the loss shall be taken conclusively to be the policy limits of the policy insuring the property.

History: 1975 c. 375; 1979 c. 73, 177; 2001 a. 65.

Cross–reference: See also ch. Ins 4, Wis. adm. code.

Arson by one spouse did not bar the other from recovering fire insurance proceeds under a jointly owned policy that insured jointly owned property. Hedtcke v. Sentry Ins. Co. 109 Wis. 2d 461, 326 N.W.2d 727 (1982).

An administrative rule interpretation of sub. (2) that denies benefits solely on the basis of a past rental of the property would be unreasonable. Kohnen v. Wisconsin Mut. Ins. Co. 111 Wis. 2d 584, 331 N.W.2d 598 (Ct. App. 1983).

To have "occupied" a dwelling under sub. (2) requires actual and physical control. An inanimate entity such as an estate is incapable of occupying a dwelling under sub. (2). Drangstviet v. Auto–Owners Insurance Co. 195 Wis. 2d 592, 536 N.W.2d 189 (Ct. App. 1995), 95–0053.

Sub. (2) does not exclude any dwellings that are owned and occupied by the insured. A building need not be exclusively residential. Seider v. O'Connell, 2000 WI 76, 236 Wis. 2d 211, 612 N.W.2d 659, 98–1223.

Sub. (2), the valued policy law, does not provide that an insured is entitled to the limits of all policies insuring a dwelling. Instead, s. 631.43 (1), the pro rata statute, specifically governs situations when two or more policies indemnify against the same loss. Absent the consent of the insurers, insureds are entitled to the full amount of their loss but not to the full amount of both policies if the combined limits exceed the actual loss. Wegner v. West Bend Mutual Insurance Company, 2007 WI App 18, 298 Wis. 2d 420, 728 N.W.2d 30, 05–3193.

Sub. (2) does not exclude real property that is owned and occupied by the insured primarily as a dwelling solely because it is not the insured's primary residence, but to be covered under the statute the property must be "occupied by the insured primarily as a dwelling." Use is the core meaning of occupy in the context of this statute. The building must be used by the insured primarily as a residence. When the primary use of a building for at least 14 months before a fire had been renting it to others, sub. (2) did not apply. Cambier v. Integrity Mutual Insurance Company, 2007 WI App 200, 305 Wis. 2d 337, 738 N.W.2d 181, 06–3112.

Sub. (2) requires the insured building be "occupied by the insured primarily as a dwelling." The insured's use must bear a relationship to actually living in the dwelling. The fact that the building was being renovated and refurbished does not affect its status as a dwelling. Whether or not a person ever slept in a house is not dispositive of whether he or she occupied it. A dwelling does not cease to be occupied as a dwelling if the people living there temporarily vacate the dwelling for renovations or if a purchaser engages in renovations before moving in. Johnson v. Mt. Morris Mutual Insurance Company, 2012 WI App 3, 338 Wis. 2d 327, 809 N.W.2d 53, 10–2468.

Administrative rules provide that real property owned and occupied by the insured that is partially destroyed but ordered razed under a fire ordinance or similar law shall be considered wholly destroyed for purposes of sub. (2). The test is not whether the property has been physically destroyed. Haynes v. American Family Mutual Insurance Company, 2014 WI App 128, 359 Wis. 2d 87, 857 N.W.2d 478, 14–0395.

632.07 Prohibiting requiring property insurance in excess of replacement value. A lender may not require a borrower, as a condition of receiving or maintaining a loan secured by real property, to insure the property against risks to improvements on the real property in an amount that exceeds the replacement value or market value of the improvements, whichever is greater.

History: 2007 a. 170.

632.08 Mortgage clause. A provision for payment to a mortgagee or other owner of a security interest in property may be contained in or added by endorsement to any insurance policy protecting against loss or destruction of or damage to property. If the insurance covers real property, any loss not exceeding $500 shall be paid to the insured mortgagor despite the provision, unless the mortgagee is a named insured.

History: 1975 c. 375; 1979 c. 102.

632.09 Choice of law. Every insurance against loss or destruction of or damage to property in this state or in the use of or income from property in this state is governed by the law of this state.

History: 1975 c. 375.

632.10 Definitions applicable to property insurance escrow. In ss. 632.10 to 632.104:

(1) "Building and safety standards" means the requirements of chs. 101 and 145 and of any rule promulgated by the department of safety and professional services under ch. 101 or 145, and standards of a 1st class city relating to the health and safety of occupants of buildings.

(2) "Deliver" means delivery in person, or delivery by deposit with the U.S. postal service of certified or 1st class mail addressed to the recipient at the recipient's last–known address.

(3) "Final settlement" means the amount that an insurer owes under a property insurance policy to the named insured and other interests named in the policy for loss to any insured building or other structure affixed to land that is caused by fire or explosion, excluding any amount payable for loss to contents or other personal property, for loss of use or business interruption and any amount payable under liability coverage under the policy, and that is determined by any of the following means:

(a) Acceptance of a proof of loss by the insurer.

(b) Execution of a release by the named insured.

(c) Acceptance of an arbitration award by the insurer and named insured.

(d) Judgment of a court of competent jurisdiction.

History: 1989 a. 347; 1995 a. 27 ss. 7041, 9116 (5); 2011 a. 32.

632.101 Policy terms. (1) AFFECTED POLICIES. Except as provided in sub. (2), every property insurance policy issued or delivered in this state, including property insurance policies issued under the mandatory risk–sharing plan operating under s. 619.01, that insures real property located in a 1st class city against loss caused by fire or explosion shall provide for payment of any final settlement under the policy in the manner described in ss. 632.102 to 632.104.

(2) EXCLUDED POLICIES. Sections 632.10 to 632.104 do not apply to property insurance policies issued in any of the following circumstances:

(a) By the local government property insurance fund under ch. 605.

(b) On a one– or 2–family dwelling that is occupied by the named insured as a principal residence, if any of the following is satisfied:

1. The named insured gives proof of occupancy to the insurer by a valid Wisconsin operator's license.

2. If the named insured does not possess a valid Wisconsin operator's license, the named insured gives proof of occupancy to the 1st class city by documentation approved by the 1st class city. Upon acceptance of the proof, the 1st class city shall immediately notify the insurer that a policy issued on the property is exempt from ss. 632.10 to 632.104.

History: 1989 a. 347; 1991 a. 315.

632.102 Payment of final settlement. (1) WITHHOLDING. An insurer shall withhold from payment a portion of the final settlement as determined under sub. (2), if all of the following apply:

(a) The amount of the final settlement exceeds 50 percent of the total of all limits under all insurance policies covering the building and any other structure affixed to land that sustained the loss.

(b) The total amount of all insurance covering the building and any other structure affixed to land that sustained the loss is at least $5,000.

(2) AMOUNT WITHHELD. The insurer shall withhold from payment of the final settlement an amount that is equal to the greater of the following:

(a) Twenty–five percent of the final settlement.

(b) The lesser of $7,500 or the limits under the policy for coverage of the building or other structure affixed to land that sustained the loss.

(3) NOTICE OF WITHHOLDING. (a) Within 10 days after withholding the amount determined under sub. (2), the insurer shall

deliver written notice of the withholding to all of the following persons:

1. The building inspection official of the 1st class city in which the insured real property is located.

2. The named insured.

3. Any mortgagee or other lienholder who has an existing lien against the insured real property and who is named in the policy.

4. If the final settlement was determined by judgment, the court in which the judgment was entered, in addition to the persons described in subds. 1. to 3.

(b) The notice of withholding shall include all of the following information:

1. The identity and address of the insurer.

2. The name and address of the named insured and each mortgagee or other lienholder entitled to notice under par. (a) 3.

3. The address of the insured real property.

4. The date of loss, policy number and claim number.

5. The amount of money withheld.

6. A summary of ss. 632.10 to 632.104, including a statement explaining all of the following:

a. That for the 1st class city to qualify for reimbursement of expenses from the funds withheld under this section, the 1st class city must, after the loss occurs but within 90 days after delivery of the notice of withholding under this subsection, commence proceedings under s. 66.0413, 254.595 or 823.04 or under a local ordinance relating to demolition or abatement of nuisances or obtain a release signed by the named insured consenting to demolition with respect to the building or other structure; that if the 1st class city commences the proceedings or obtains the release within that time period, a part or all of the withheld funds may be used to defray the 1st class city's expenses; and that the withheld funds will be released to the named insured and other interests named in the policy if the 1st class city does not commence the proceedings or obtain the release within that time period.

b. That the withheld funds may be released to the named insured and other interests named in the policy if an official of the 1st class city determines under s. 632.103 (3) that the building or other structure has been repaired or replaced or the site restored to a dust–free and erosion–free condition.

(4) INSURER'S LIABILITY. In no event may an insurer be liable under a policy subject to ss. 632.10 to 632.104 for any amount greater than the lesser of the final settlement or the limits of liability set out in the policy.

(5) IMMUNITY FOR INSURER. No cause of action may arise against and no liability may be imposed upon an insurer or an agent or employee of an insurer for paying, withholding or transferring all or any portion of a final settlement as provided in ss. 632.10 to 632.104.

History: 1989 a. 347; 1993 a. 27; 1995 a. 27; 1999 a. 150 s. 672.

632.103 Procedure for payment of withheld funds. (1) RELEASE TO 1ST CLASS CITY. (a) To qualify for reimbursement of expenses under sub. (2), the 1st class city must do any of the following:

1. Commence proceedings under s. 66.0413, 254.595 or 823.04 or under a local ordinance relating to demolition or abatement of nuisances, with respect to the building or other structure for which the funds are withheld.

2. Obtain a release signed by the named insured consenting to demolition of the building or other structure with respect to which the funds are withheld.

(b) The 1st class city shall commence proceedings under par. (a) 1. or obtain the release under par. (a) 2. after the occurrence of the loss to the building or other structure by fire or explosion but within 90 days after delivery of the notice of withholding under s. 632.102 (3).

(c) When proceedings described in par. (a) 1. are commenced, the 1st class city shall notify, in writing, the insurer, the named insured and any mortgagee or other lienholder identified in the notice of withholding under s. 632.102 (3) (b) 2. that the proceedings are commenced.

(d) The 1st class city shall release all interest in the amount withheld under s. 632.102 (2) and the insurer shall promptly pay that amount to the named insured and other interests named in the policy if any of the following occurs:

1. The 1st class city fails to commence proceedings described in par. (a) 1. or obtain a release described in par. (a) 2. within the period provided in par. (b).

2. The 1st class city fails to notify the insurer as provided in par. (c).

(2) REIMBURSEMENT OF EXPENSES. (a) If the 1st class city satisfies sub. (1) (a) and (b) and, if applicable, notifies the insurer as required in sub. (1) (c), the insurer shall promptly upon receiving the statement under par. (b) deliver to the 1st class city funds withheld from the named insured's final settlement under s. 632.102 (2), to the extent necessary to reimburse the 1st class city for any of the following expenses:

1. Costs incurred in the course of enforcing ss. 66.0413 and 66.0427 or a local ordinance relating to demolition, with respect to the building or other structure for which the funds are withheld.

2. Costs incurred in acting in accordance with a release signed by the named insured consenting to demolition of the building or other structure with respect to which the funds are withheld.

3. Costs incurred in abating a public nuisance under s. 254.595 or 823.04 or under a local ordinance relating to abating a public nuisance, with respect to the building or other structure for which the funds are withheld.

4. Reasonable administrative expenses incurred in connection with activities described in subds. 1. to 3., including but not limited to expenses for inspection, clerical, supervisory and attorney services.

(b) The insurer may not release any withheld funds to the 1st class city under par. (a) unless the 1st class city delivers to the insurer and the named insured an itemized statement of the actual costs incurred under par. (a) 1. to 4.

(c) The insurer shall promptly deliver to the named insured and other interests named in the policy any portion of the withheld funds that are not released to the 1st class city under par. (a).

(3) RELEASE TO NAMED INSURED. Except as provided in sub. (2), the insurer shall promptly deliver to the named insured and other interests named in the policy the funds withheld from the named insured's final settlement under s. 632.102 (2) if the 1st class city delivers a notice to the insurer that the building inspection official of the 1st class city, or other person who is authorized by the 1st class city's governing body to represent the 1st class city, has inspected the insured real property and verifies any of the following:

(a) That the damaged or destroyed portions of the building or other structure with respect to which the funds are withheld have been repaired or replaced in compliance with applicable building and safety standards, except to the extent that the withheld funds are needed to complete repair or replacement.

(b) That the damaged or destroyed building or other structure with respect to which the funds are withheld and all remnants of the building or other structure have been removed from the land on which the building or other structure was situated and the site has been restored to a dust–free and erosion–free condition in compliance with applicable building and safety standards.

History: 1989 a. 347; 1991 a. 32; 1993 a. 27; 1999 a. 150 ss. 663, 672.

632.104 Funds released to mortgagee. (1) FIRST MORTGAGE IN DEFAULT. The insurer shall release to a mortgagee funds withheld under s. 632.102, in an amount and within the period provided in sub. (2), if all of the following conditions are satisfied:

(a) The mortgagee holds a first mortgage on the real property with respect to which the funds are being withheld, and the mortgage is in default.

(b) The mortgage was executed before March 1, 1991.

(c) The mortgagee delivers to the insurer a written request for release of the funds within 15 days after delivery of the notice of withholding under s. 632.102 (3).

(2) AMOUNT RELEASED; TIMING. If sub. (1) is satisfied, the insurer shall release to the mortgagee all or any portion of the funds withheld with respect to the mortgaged property as is necessary to satisfy an outstanding first lien mortgage of the mortgagee. The insurer shall release the funds within 10 days after receiving the request under sub. (1) (c).

History: 1989 a. 347.

SUBCHAPTER II

SURETY INSURANCE

632.14 Bonds need not be under seal. No suretyship obligation need be under seal unless a seal is required by the applicable federal law or law of another jurisdiction.

History: 1975 c. 375.

632.17 Validity of surety bonds. (1) FAILURE TO FILE CERTIFICATE. No instrument executed by an insurer authorized to do a surety business is ineffective because of failure to file the certificate of its authority to do business in this state or a certified copy thereof; but the officer with whom any instrument so executed has been filed or any person who might claim the benefit thereof may by written notice require the person filing the instrument to have a certified copy of the certificate of authority filed with the officer, and unless the copy is filed within 8 days after receipt of the notice the instrument does not satisfy the requirement that the instrument be supplied.

(2) SATISFACTION OF OBLIGATIONS TO PROVIDE SURETY. An undertaking in appropriate terms issued by an insurer authorized to do a surety business satisfies and is complete compliance with any authorization or requirement in the law of this state respecting surety bonds, undertakings or other similar obligations, and shall be accepted as such by any official authorized to receive or empowered to require such an undertaking, subject to sub. (1).

History: 1975 c. 375.

632.18 Rustproofing warranties insurance. A policy of insurance to cover a warranty, as defined in s. 100.205 (1) (g), shall fully cover the financial integrity of the warranty.

History: 1985 a. 29.

632.185 Vehicle protection product warranty insurance policy. (1) In this section:

(a) "Vehicle protection product" has the meaning given in s. 100.203 (1) (e).

(b) "Warrantor" has the meaning given in s. 100.203 (1) (f).

(c) "Warranty" has the meaning given in s. 100.203 (1) (g).

(d) "Warranty holder" has the meaning given in s. 100.203 (1) (h).

(e) "Warranty reimbursement insurance policy" has the meaning given in s. 100.203 (1) (i).

(2) A warranty reimbursement insurance policy that is issued, sold, or offered for sale in this state shall meet all of the following conditions:

(a) The policy is issued by an insurer authorized to do business in this state.

(b) The policy states that the issuer of the policy will reimburse or pay on behalf of the warrantor all covered sums that the warrantor is legally obligated to pay or will provide the service that the warrantor is legally obligated to perform according to the warrantor's contractual obligations under the provisions of the insured warranties sold by the warrantor.

(c) The policy states that if the warrantor does not provide payment due under the terms of the warranty within 60 days after the warranty holder has filed proof of loss according to the terms of the warranty, the warranty holder may file for a reimbursement directly with the issuer of the warranty reimbursement insurance policy.

(d) The policy provides that the issuer of the warranty reimbursement insurance policy has received payment of the premium if the warranty holder paid for the vehicle protection product covered under the insured warranty and that the insurer's liability under the policy may not be reduced or relieved by a failure of the warrantor to report to the insurer the issuance of a warranty.

(e) The policy contains the following provisions regarding cancellation:

1. The policy may not be canceled by the issuer until a written notice of cancellation has been mailed or delivered to the commissioner and the insured warrantor.

2. The cancellation of the policy does not reduce the issuer's responsibility with respect to warranties that apply to vehicle protection products sold prior to the date of cancellation.

3. If the warrantor has filed the policy with the commissioner and the issuer cancels the policy, the warrantor shall do one of the following:

a. File a copy of a new policy with the commissioner, before the termination of the prior policy, providing no lapse in coverage following the termination of the prior policy.

b. Discontinue acting as a warrantor as of the termination date of the policy until a new policy becomes effective and the commissioner accepts it.

History: 2003 a. 302.

Cross–reference: See also ch. Ins 14, Wis. adm. code.

SUBCHAPTER III

LIABILITY INSURANCE IN GENERAL

632.22 Required provisions of liability insurance policies. Every liability insurance policy shall provide that the bankruptcy or insolvency of the insured shall not diminish any liability of the insurer to 3rd parties and that if execution against the insured is returned unsatisfied, an action may be maintained against the insurer to the extent that the liability is covered by the policy.

History: 1975 c. 375.

632.23 Prohibited exclusions in aircraft insurance policies. No policy covering any liability arising out of the ownership, maintenance or use of an aircraft, may exclude or deny coverage because the aircraft is operated in violation of air regulation, whether derived from federal or state law or local ordinance.

History: 1975 c. 375.

632.24 Direct action against insurer. Any bond or policy of insurance covering liability to others for negligence makes the insurer liable, up to the amounts stated in the bond or policy, to the persons entitled to recover against the insured for the death of any person or for injury to persons or property, irrespective of whether the liability is presently established or is contingent and to become fixed or certain by final judgment against the insured.

History: 1975 c. 375.

An excess–of–policy coverage clause in a reinsurance agreement constituted a liability insurance contract insuring against tortious failure to settle a claim. Ott v. All–Star Ins. Corp., 99 Wis. 2d 635, 299 N.W.2d 839 (1981).

Recovery limitations applicable to an insured municipality likewise applied to its insurer, notwithstanding higher policy limits and s. 632.24. Gonzalez v. City of Franklin, 137 Wis. 2d 109, 430 N.W.2d 747 (1987).

Insurers must plead and prove their policy limits prior to a verdict in order to restrict the judgment to the policy limits. Price v. Hart, 166 Wis. 2d 182, 480 N.W.2d 249 (Ct. App. 1991).

This section does not apply to actions in which the principal on a bond under s. 344.36 causes injury. That section requires obtaining a judgment against the principal before an action may be brought against the surety. Vansguard v. Progressive Northern Insurance Co., 188 Wis. 2d 584, 525 N.W.2d 146 (Ct. App. 1994).

There is neither a statutory nor a constitutional right to have all parties identified to a jury, but as a procedural rule, the court should in all cases apprise the jurors of the names of all the parties. Stoppleworth v. Refuse Hideway, Inc., 200 Wis. 2d 512, 546 N.W.2d 870 (Ct. App. 1996), 93–3182.

The insured stands in privity with the insurer under this section. There is but one wrong and but one cause of action. When liability cannot be imposed upon one, none can be imposed upon the other. Plaintiff's cashing of the defendant's insurer's settlement check demonstrated an accord and satisfaction of claims against the insured although the insured had not been named in the action. Parsons v. American Family Insurance Co., 2007 WI App 211, 305 Wis. 2d 630, 740 N.W.2d 399, 06–2481.

This section allows direct actions against a negligence insurer for negligence claims. It does not allow a plaintiff in a contract action to sue the defendant's insurer. Rogers v. Saunders, 2008 WI App 53, 309 Wis. 2d 238, 750 N.W.2d 477, 07–0306.

This section does not speak to whether the timely answer of an insured denying liability may inure to the benefit of a defaulting insurance company so as to preclude a judgment by default against it for the plaintiff's damages. The timely answer of the codefendant insureds denying the liability of all defendants did not preclude default judgment against the insurer on the issue of liability and damages upon the insurer's acknowledged default. Estate of Otto v. Physicians Insurance Company of Wisconsin, Inc., 2008 WI 78, 311 Wis. 2d 84, 751 N.W.2d 805, 06–1566.

This section applies to any policy of insurance covering liability, irrespective of whether that policy was delivered or issued for delivery in Wisconsin, so long as the accident or injury occurs in this state. Casper v. American International South Insurance Co., 2011 WI 81, 336 Wis. 2d 267, 800 N.W.2d 880, 06–1229.

This section does not mandate a pro rata distribution of the policy limits among all claimants. The statute is silent as to how the policy limit is to be distributed. Until such time as there was a verdict in this case, policy limits paid into court were not subject to the circuit court's control and neither the direct action statute nor Wisconsin case law required the court to distribute its policy limits in settlement on a pro rata basis. Lovelien v. Austin Mutual Insurance Co., 2018 WI App 4, 379 Wis. 2d 733, 906 N.W.2d 728, 16–1679.

The direct action statute generally endeavors to save litigation and reduce expense by determining the rights of all parties in a single action involving the insurance carrier, to expedite the final settlement of litigation and payment to the injured person, and to place the burden on the insurer to pay damages sustained by a person as a result of the insured's causal negligence. However, when an injured party pursues claims for damages arising out of an accident directly against an insured's liability insurer under this section without the insured being made a party to that action, claim preclusion does not bar the insured from pursuing a negligence claim in a subsequent lawsuit against the injured party. Hull v. Glewwe, 2019 WI App 27, 388 Wis. 2d 90, 931 N.W.2d 266, 17–2485.

The federal compulsory counterclaim rule precluded an action against an insurer under the state direct action statute when an action directly against the insured was barred by rule. Fagnan v. Great Central Ins. Co., 577 F.2d 418 (1978).

A breach of fiduciary duty was negligence for purposes of Wisconsin's direct action and direct liability statutes. Federal Deposit Insurance Co. v. MGIC Indemnity Corp., 462 F. Supp. 759 (1978).

An insurer's failure to join in an insured motorist's petition to remove the case to federal court necessitated a remand to state court. Padden v. Gallaher, 513 F. Supp. 770 (1981).

632.25 Limited effect of conditions in employer's liability policies. Any condition in an employer's liability policy requiring compliance by the insured with rules concerning the safety of persons shall be limited in its effect in such a way that in the event of breach by the insured the insurer shall nevertheless be responsible to the injured person under s. 632.24 as if the condition has not been breached, but shall be subrogated to the injured person's claim against the insured and be entitled to reimbursement by the latter.

History: 1975 c. 375.

"Condition" as used in this section does not refer to exclusion. Bortz v. Merrimac Mutual Insurance Co. 92 Wis. 2d 865, 286 N.W.2d 16 (Ct. App. 1979).

632.26 Notice provisions. (1) REQUIRED PROVISIONS. Every liability insurance policy shall provide:

(a) That notice given by or on behalf of the insured to any authorized agent of the insurer within this state, with particulars sufficient to identify the insured, is notice to the insurer.

(b) That failure to give any notice required by the policy within the time specified does not invalidate a claim made by the insured if the insured shows that it was not reasonably possible to give the notice within the prescribed time and that notice was given as soon as reasonably possible.

(2) EFFECT OF FAILURE TO GIVE NOTICE. Failure to give notice as required by the policy as modified by sub. (1) (b) does not bar liability under the policy if the insurer was not prejudiced by the failure, but the risk of nonpersuasion is upon the person claiming there was no prejudice.

History: 1979 c. 102.

Legislative Council Note, 1979: Subsection (1) is former s. 632.32 (1), altered in 2 ways: (1) to extend its coverage to all liability policies; and (2) to change "may" to "shall". The subsection is divided into 2 paragraphs for clarity.

The first change would strengthen the law. It is entirely new and seems a desirable extension.

The second change corrects an error. The word "shall" was used in the fourth draft of the bill that ultimately became ch. 375, laws of 1975, and was not changed in the addendum to the fourth draft, dated July 14, 1975. Those documents went to the insurance laws revision committee and then to the legislative council for action. Nothing appears in the minutes of the committee's meeting of July 14, 1975 to indicate that a change was made. But in LRB–6218/1 of 1975, "may" appears instead of "shall". That error, which was probably inadvertent and the source of which we have not been able to trace, was carried on into the final enactment.

Sub. (2) continues the second sentence of former s. 632.34 (4). Shifting it to s. 632.26, which is applicable to all liability insurance, broadens its application, but that seems desirable. The term "burden of proof" is changed to "risk of nonpersuasion" to tighten up the meaning. "Burden of proof" is a broad term that comprehends 2 separate concepts: (1) the burden of going forward with the evidence and (2) the burden of persuading the trier of fact, better termed the "risk of nonpersuasion". See McCormick, Evidence, (2nd ed.), at 784 n. 4 (1972). The statute is concerned with determining who wins when the totality of evidence is inconclusive, not with the burden of going forward, which ought to be settled on the basis of general principles. Indeed, since the insurer will have best (or the only) access to information about prejudice, it may be quite unfair to put the burden of going forward on the claimant.

Subs. (1) (b) and (2) are related. The first is a required provision in the policy. The 2nd is a rule of law. It is preferable not to go too far in inserting excuses into the policy. Sub. (1) (b) encourages the insured not to give up automatically if notice is not timely given, but insertion of sub. (2) into the policy would arguably encourage an unduly long delay that might prejudice both parties. [Bill 146–S]

When the insurer denied coverage within the time that the insured could have submitted her proofs in response to the insurer's request for more information, the insurer waived the defense of lack of notice. Ehlers v. Colonial Penn Insurance Co. 81 Wis. 2d 64, 259 N.W.2d 718 (1977).

The failure of policyholders to give notice to an underinsurer of a settlement between the insured and the tortfeasor does not bar underinsured motorist coverage in the absence of prejudice to the insurer. There is a rebuttable presumption of prejudice when there is a lack of notice, with the burden on the insured to prove by the greater weight of the evidence that the insurer was not prejudiced. Ranes v. American Family Mutual Insurance Co. 219 Wis. 2d 49, 580 N.W.2d 197 (1998), 97–0441.

Wisconsin's notice–prejudice statutes, this section and s. 631.81, do not supersede the reporting requirement specific to claims–made–and–reported policies. Anderson v. Aul, 2015 WI 19, 361 Wis. 2d 63, 862 N.W.2d 304, 13–0500.

SUBCHAPTER IV

AUTOMOBILE AND MOTOR VEHICLE INSURANCE

632.32 Provisions of motor vehicle insurance policies. (1) SCOPE. Except as otherwise provided, this section applies to every policy of insurance issued or delivered in this state against the insured's liability for loss or damage resulting from accident caused by any motor vehicle, whether the loss or damage is to property or to a person.

(2) DEFINITIONS. In this section:

(ab) "Commercial automobile liability policy" means a liability insurance policy that is intended principally to provide primary coverage for the insured's liability arising out of the ownership, maintenance, or use of a motor vehicle in the insured's business or other commercial activities.

(ac) "Commercial liability policy" means any form of liability insurance policy, including a commercial or business package policy or a policy written on farm and agricultural operations, that is intended principally to provide primary coverage for the insured's general liability arising out of its business or other commercial activities, and that includes coverage for the insured's liability arising out of the ownership, maintenance, or use of a motor vehicle as only one component of the policy or as coverage that is only incidental to the principal purpose of the policy. "Commercial liability policy" does not include a worker's compensation policy or a commercial automobile liability policy.

(ag) "Governmental unit" has the meaning given in s. 50.33 (1r).

(am) "Medical payments coverage" means coverage to indemnify for medical payments or chiropractic payments or both for the protection of all persons using the insured motor vehicle from losses resulting from bodily injury or death.

(at) "Motor vehicle" means a self–propelled land motor vehicle designed for travel on public roads and subject to motor vehicle registration under ch. 341. A trailer or semitrailer that is

designed for use with and connected to a motor vehicle shall be considered a single unit with the motor vehicle. "Motor vehicle" does not include farm tractors, well drillers, road machinery, or snowmobiles.

(b) "Motor vehicle handler" means any of the following:

1. A motor vehicle dealer, as defined in s. 218.0101 (23) (a).

2. A lessor, as defined in s. 344.51 (1g) (a), or a rental company, as defined in s. 344.51 (1g) (c).

3. A repair shop, service station, storage garage or public parking place.

(be) "Owned motor vehicle" means a motor vehicle that is owned by the insured or that is leased by the insured for a term of 6 months or longer.

(bh) "Phantom motor vehicle" means a motor vehicle to which all of the following apply:

1. The motor vehicle is involved in an accident with a person who has uninsured motorist coverage.

2. In the accident, the motor vehicle makes no physical contact with the insured or with a vehicle the insured is occupying.

3. The identity of neither the operator nor the owner of the motor vehicle can be ascertained.

(cm) "Umbrella or excess liability policy" means an insurance contract providing at least $1,000,000 of liability coverage per person or per occurrence in excess of certain required underlying liability insurance coverage or a specified amount of self–insured retention.

(d) "Underinsured motorist coverage" means coverage for the protection of persons insured under that coverage who are legally entitled to recover damages for bodily injury, death, sickness, or disease from owners or operators of underinsured motor vehicles.

(f) "Uninsured motorist coverage" means coverage for the protection of persons insured under that coverage who are legally entitled to recover damages for bodily injury, death, sickness, or disease from owners or operators of uninsured motor vehicles.

(g) "Uninsured motor vehicle" means a motor vehicle, other than a motor vehicle owned by a governmental unit, that is involved in an accident with a person who has uninsured motorist coverage and with respect to which, at the time of the accident, a bodily injury liability insurance policy is not in effect and the owner or operator has not furnished proof of financial responsibility for the future under subch. III of ch. 344 and is not a self–insurer under any other applicable motor vehicle law. "Uninsured motor vehicle" also includes any of the following motor vehicles, other than a motor vehicle owned by a governmental unit, involved in an accident with a person who has uninsured motorist coverage:

1. An insured motor vehicle, or a motor vehicle with respect to which the owner or operator is a self–insurer under any applicable motor vehicle law, if before or after the accident the liability insurer of the motor vehicle, or the self–insurer, is declared insolvent by a court of competent jurisdiction.

2. A phantom motor vehicle, if all of the following apply:

a. The facts of the accident are corroborated by competent evidence that is provided by someone other than the insured or any other person who makes a claim against the uninsured motorist coverage as a result of the accident.

b. Within 72 hours after the accident, the insured or someone on behalf of the insured reports the accident to a police, peace, or judicial officer or to the department of transportation or, if the accident occurs outside of Wisconsin, the equivalent agency in the state where the accident occurs.

c. Within 30 days after the accident occurs, the insured or someone on behalf of the insured files with the insurer a statement under oath that the insured or a legal representative of the insured has a cause of action arising out of the accident for damages against a person whose identity is not ascertainable and setting forth the facts in support of the statement.

3. An unidentified motor vehicle involved in a hit–and–run accident with the person.

(h) "Using" includes driving, operating, manipulating, riding in and any other use.

(3) REQUIRED PROVISIONS. Except as provided in sub. (5), every policy subject to this section issued to an owner shall provide that:

(a) Coverage provided to the named insured applies in the same manner and under the same provisions to any person using any motor vehicle described in the policy when the use is for purposes and in the manner described in the policy.

(b) Coverage extends to any person legally responsible for the use of the motor vehicle.

(4) REQUIRED UNINSURED MOTORIST AND MEDICAL PAYMENTS COVERAGES. (a) Except as provided in par. (d), every policy of insurance subject to this section that insures with respect to any motor vehicle registered or principally garaged in this state against loss resulting from liability imposed by law for bodily injury or death suffered by any person arising out of the ownership, maintenance, or use of a motor vehicle shall contain therein or supplemental thereto provisions for all of the following coverages:

1. Excluding a policy written by a town mutual organized under ch. 612, uninsured motorist coverage, in limits of at least $25,000 per person and $50,000 per accident.

2. Medical payments coverage, in the amount of at least $1,000 per person. Coverage written under this subdivision may be excess coverage over any other source of reimbursement to which the insured person has a legal right.

(bc) Notwithstanding par. (a) 2., the named insured may reject medical payments coverage. If one named insured rejects the coverage, the coverage need not be provided in a subsequent renewal policy issued by the same insurer unless a named insured under the policy requests it in writing.

(c) Unless an insurer waives the right to subrogation, insurers making payment under any of the coverages under this subsection shall, to the extent of the payment, be subrogated to the rights of their insureds.

(d) This subsection does not apply to a commercial liability policy if the coverage it provides for the insured's liability arising out of the maintenance or use of a motor vehicle is limited to coverage for motor vehicles that are not owned motor vehicles, or to an umbrella or excess liability policy. If a commercial liability policy or an umbrella or excess liability policy provides medical payments coverage or uninsured motorist coverage, however, the coverage must have limits of at least those specified in par. (a).

Cross–reference: See also s. Ins 6.77, Wis. adm. code.

(4m) UNDERINSURED MOTORIST COVERAGE. (a) Except as provided in par. (e), an insurer writing policies that insure with respect to a motor vehicle registered or principally garaged in this state against loss resulting from liability imposed by law for bodily injury or death suffered by a person arising out of the ownership, maintenance, or use of a motor vehicle shall provide to one named insured under each such insurance policy that goes into effect after November 1, 2011, that is written by the insurer and that does not include underinsured motorist coverage written notice of the availability of underinsured motorist coverage, including a brief description of the coverage. An insurer is required to provide the notice required under this paragraph only one time and in conjunction with the delivery of the policy.

(b) Acceptance or rejection of underinsured motorist coverage by a person after being notified under par. (a) need not be in writing. The absence of a premium payment for underinsured motorist coverage is conclusive proof that the person has rejected such coverage. The rejection of such coverage by the person notified under par. (a) shall apply to all persons insured under the policy, including any renewal of the policy.

(c) If a person rejects underinsured motorist coverage after being notified under par. (a), the insurer is not required to provide such coverage under a policy that is renewed to the person by that insurer unless an insured under the policy subsequently requests such underinsured motorist coverage in writing.

(d) If an insured accepts underinsured motorist coverage, the insurer shall include the coverage in limits of at least $50,000 per person and $100,000 per accident.

(e) This subsection does not apply to a commercial liability policy if the coverage it provides for the insured's liability arising out of the maintenance or use of a motor vehicle is limited to coverage for motor vehicles that are not owned motor vehicles, or to an umbrella or excess liability policy. If a commercial liability policy or an umbrella or excess liability policy provides underinsured motorist coverage, however, the coverage must have limits of at least those specified in par. (d).

(5) PERMISSIBLE PROVISIONS. (a) A policy may limit coverage to use that is with the permission of the named insured or, if the insured is an individual, to use that is with the permission of the named insured or an adult member of that insured's household other than a chauffeur or domestic servant. The permission is effective even if it violates s. 343.45 (2) and even if the use is not authorized by law.

(b) If the policy is issued to anyone other than a motor vehicle handler, it may limit the coverage afforded to a motor vehicle handler or its officers, agents or employees to the limits under s. 344.01 (2) (d) and to instances when there is no other valid and collectible insurance with at least those limits whether the other insurance is primary, excess or contingent.

(c) If the policy is issued to a motor vehicle handler, it may restrict coverage afforded to anyone other than the motor vehicle handler or its officers, agents or employees to the limits under s. 344.01 (2) (d) and to instances when there is no other valid and collectible insurance with at least those limits whether the other insurance is primary, excess or contingent.

(d) If a motor vehicle covered by the policy is sold or transferred, the purchaser or transferee is not an additional insured unless the consent of the insurer is endorsed on the policy.

(e) A policy may provide for exclusions not prohibited by sub. (6) or other applicable law. Such exclusions are effective even if incidentally to their main purpose they exclude persons, uses or coverages that could not be directly excluded under sub. (6) (b).

(f) A policy may provide that, regardless of the number of policies involved, vehicles involved, persons covered, claims made, vehicles or premiums shown on the policy, or premiums paid, the limits for any coverage under the policy may not be added to the limits for similar coverage applying to other motor vehicles to determine the limit of insurance coverage available for bodily injury or death suffered by a person in any one accident.

(g) A policy may provide that the maximum amount of uninsured motorist coverage, underinsured motorist coverage, or medical payments coverage available for bodily injury or death suffered by a person who was not using a motor vehicle at the time of an accident is the highest single limit of uninsured motorist coverage, underinsured motorist coverage, or medical payments coverage, whichever is applicable, for any motor vehicle with respect to which the person is insured.

(i) A policy may provide that the limits under the policy for uninsured motorist coverage or underinsured motorist coverage for bodily injury or death resulting from any one accident shall be reduced by any of the following that apply:

1. Amounts paid by or on behalf of any person or organization that may be legally responsible for the bodily injury or death for which the payment is made.

2. Amounts paid or payable under any worker's compensation law.

3. Amounts paid or payable under any disability benefits laws.

(j) A policy may provide that any coverage under the policy does not apply to a loss resulting from the use of a motor vehicle that meets all of the following conditions:

1. Is owned by the named insured, or is owned by the named insured's spouse or a relative of the named insured if the spouse or relative resides in the same household as the named insured.

2. Is not described in the policy under which the claim is made.

3. Is not covered under the terms of the policy as a newly acquired or replacement motor vehicle.

(6) PROHIBITED PROVISIONS. (a) No policy issued to a motor vehicle handler may exclude coverage upon any of its officers, agents or employees when any of them are using motor vehicles owned by customers doing business with the motor vehicle handler.

(b) No policy may exclude from the coverage afforded or benefits provided:

1. Persons related by blood, marriage or adoption to the insured.

2. a. Any person who is a named insured or passenger in or on the insured vehicle, with respect to bodily injury, sickness or disease, including death resulting therefrom, to that person.

b. This subdivision, as it relates to passengers, does not apply to a policy of insurance for a motorcycle as defined in s. 340.01 (32) or a moped as defined in s. 340.01 (29m) if the motorcycle or moped is designed to carry only one person and does not have a seat for any passenger.

3. Any person while using the motor vehicle, solely for reasons of age, if the person is of an age authorized to drive a motor vehicle.

4. Any use of the motor vehicle for unlawful purposes, or for transportation of liquor in violation of law, or while the driver is under the influence of an intoxicant or a controlled substance or controlled substance analog under ch. 961 or a combination thereof, under the influence of any other drug to a degree which renders him or her incapable of safely driving, or under the combined influence of an intoxicant and any other drug to a degree which renders him or her incapable of safely driving, or any use of the motor vehicle in a reckless manner. In this subdivision, "drug" has the meaning specified in s. 450.01 (10).

(c) No policy may limit the time for giving notice of any accident or casualty covered by the policy to less than 20 days.

History: 1975 c. 375, 421; 1979 c. 102, 104; 1979 c. 177 ss. 67, 68; 1979 c. 221; 1981 c. 284; 1983 a. 243, 459; 1985 a. 146 s. 8; 1995 a. 21, 448; 1997 a. 48; 1999 a. 31, 162; 2007 a. 168; 2009 a. 28, 342; 2011 a. 14, 224.

NOTE: Wisconsin Statutes 1979 to 2009 all contain an extensive 1979 Legislative Council Note regarding the recodification of prior statutes by 1979 Laws, ch. 102, as s. 632.32.

NOTE: 1995 Wisconsin Act 21, which became effective July 15, 1995, made significant changes in the law regarding the "stacking" of insurance policy coverage.

NOTE: 2009 Wisconsin Act 28, made significant changes to this section, effective November 1, 2009, regarding uninsured and underinsured motorist coverage, as well as stacking and reducing insurance policy coverage.

NOTE: 2011 Wisconsin Act 14, made significant changes to this section, effective November 1, 2011, regarding uninsured and underinsured motorist coverage, as well as stacking and reducing insurance policy coverage, including the reversal of many of the changes made by 2009 Wisconsin Act 28.

A "family exclusion clause" valid in the state of policy issuance will be given effect in Wisconsin. Knight v. Heritage Mutual Insurance Co. 71 Wis. 2d 821, 239 N.W.2d 348 (1976).

The concept of permissive use is the same regardless of whether it arises under the "any motor vehicle" coverage section of s. 344.33 (2) or the omnibuses coverage statute. Gross v. Joecks, 72 Wis. 2d 583, 241 N.W.2d 727 (1976).

A "fellow employee" exclusion clause is only valid if the tort–feasor and injured party are employees of the named insured and employer is required to provide worker's compensation coverage. Dahm v. Employers Mutual Liability Insurance Co. 74 Wis. 2d 123, 246 N.W.2d 131 (1976).

A spouse who was not party to the contract, reasonably believing that coverage existed after the insured spouse's death, must be given a grace period before having to comply with technical, not commonly known provisions of a policy. Handal v. American Farmers Mutual Casualty Co. 79 Wis. 2d 67, 255 N.W.2d 903 (1977).

Generally when a permissive user of a vehicle is the real owner of the car for all practical purposes, but not the named insured, and the permissive user grants permission for a 3rd person to use the vehicle, the named insured's permission is implied. American Family Mutual Insurance Co. v. Osusky, 90 Wis. 2d 142, 279 N.W.2d 719 (Ct. App. 1979).

Injury to a police officer who was stabbed while unloading beer cans from an automobile did not arise out of use of the automobile. Tomlin v. State Farm Mutual Auto. Insurance Co. 95 Wis. 2d 215, 290 N.W.2d 285 (1980).

Third parties may recover against an insurer even though the insured's fraudulent application voided the policy under s. 631.11. Rauch v. American Family Insurance Co. 115 Wis. 2d 257, 340 N.W.2d 478 (1983).

Arguments that "reduction clauses" in uninsured motorist provisions were invalid and that a release did not bar subsequent a claim against the insurer for bad faith were frivolous. Radlein v. Industrial Fire & Casualty Insurance Co. 117 Wis. 2d 605, 345 N.W.2d 874 (1984).

A "drive other car" exclusion that prohibited stacking of uninsured motorist benefits against the same insurer was voided by s. 631.43. Welch v. State Farm Mutual Automobile Insurance Co. 122 Wis. 2d 172, 361 N.W.2d 680 (1985).

A reducing clause in an uninsured motorist provision was voided by [former] sub. (4) (a). Nicholson v. Home Insurance Cos. 137 Wis. 2d 581, 405 N.W.2d 327 (1987).

Because uninsured motorist coverage is "personal and portable," the claimant was covered by a policy on a vehicle not involved in the accident. Parks v. Waffle, 138 Wis. 2d 70, 405 N.W.2d 690 (Ct. App. 1987).

Loss of consortium is not a separate bodily injury under a policy's "each person" limitation. Landsinger v. American Family Mutual Insurance Co. 142 Wis. 2d 138, 417 N.W.2d 899 (Ct. App. 1987).

An insurer could not avoid uninsured motorist coverage based on a policy provision excluding resident relatives who own their own car. Hulsey v. American Family Mutual Insurance Co. 142 Wis. 2d 639, 419 N.W.2d 288 (Ct. App. 1987).

A reducing clause and "regular use" exclusionary clause violated [former] sub. (4) (a). Niemann v. Badger Mutual Insurance Co. 143 Wis. 2d 73, 420 N.W.2d 378 (Ct. App. 1988).

An auto insurer who pays under an uninsured motorist provision is not a tortfeasor or tortfeasor's insurer against whom an injured insured's medical insurer may assert a subrogation claim. Employers Health Insurance v. General Casualty Company of Wisconsin, 161 Wis. 2d 937, 469 N.W.2d 172 (1991).

A policy may expand but not reduce uninsured motorist coverage. The policy, not the statute, determines coverage beyond the statutory requirements. Fletcher v. Aetna Casualty & Surety Co. 165 Wis. 2d 350, 477 N.W.2d 90 (Ct. App. 1991).

A policy cannot limit uninsured motorist coverage to occupants of vehicles. St. Paul Mercury Insurance Co. v. Zastrow, 166 Wis. 2d 423, 480 N.W.2d 8 (1992).

If the insurer of a vehicle becomes insolvent, the vehicle is uninsured under [former] sub. (4) (a) 2. even though an insurance guaranty association assumes the liability of the insolvent insurer. Fritsche v. Ford Motor Credit Co. 171 Wis. 2d 280, 491 N.W.2d 119 (Ct. App. 1992).

To take advantage of sub. (5) (c), a policy must include language that either says permissive users are restricted to the minimum statutory limits of liability or that users may not avail themselves of the policy unless there is no other valid collectible insurance. Carrell v. Wolken, 173 Wis. 2d 426, 496 N.W.2d 651 (Ct. App. 1992). See also Henry v. General Casualty Co. 225 Wis. 2d 849, 593 N.W.2d 913 (Ct. App. 1999), 98−2428; Pemper v. Hoel, 2004 WI App 67, 271 Wis. 2d 442, 677 N.W.2d 705, 03−2134.

A reducing clause that is unavailable to a tortfeasor and seeks to reduce uninsured motorist benefits by amounts received under worker's compensation is invalid. United Fire & Casualty Co. v. Kleppe, 174 Wis. 2d 637, 498 N.W.2d 226 (1993).

Adult members of a named insured's household are capable of giving themselves permission to drive under sub. (5). When the named insured is a corporation and the insurer knows the vehicle is owned by a corporation employee, the owner will be treated as the named insured under sub. (5). Home Insurance Co. v. Phillips, 175 Wis. 2d 104, 499 N.W.2d 193 (Ct. App. 1993).

When a premium has been paid for underinsured motorist coverage under which no benefits may ever be paid due to the application of policy definitions, the coverage is illusory and against public policy. Hoglund v. Secura Insurance, 176 Wis. 2d 265, 500 N.W.2d 354 (Ct. App. 1993).

Despite policy restrictions to the contrary, under sub. (3) separate coverage must be provided to both a named insured and an additional insured when both are actively negligent. Iaquinta v. Allstate Insurance Co. 180 Wis. 2d 661, 510 N.W.2d 715 (Ct. App. 1993).

[Former] sub. (4) (a) did not require the named insured in commercial fleet policies, if the named insured is a corporation or government entity, to be interpreted as including all of the entity's employees. Meyer v. City of Amery, 185 Wis. 2d 537, 518 N.W.2d 296 (Ct. App. 1994).

The uninsured motorist coverage requirements of s. 632.32 are inapplicable to self−insured entities under s. 344.16. Classified Insurance Co. v. Budget Rent−A−Car Inc. 186 Wis. 2d 476, 521 N.W.2d 478 (Ct. App. 1994).

Sub. (3) (a) does not apply to uninsured motorist coverage so that a permissive user is entitled to increased coverage limits purchased for specifically named persons not including the user. American Hardware Mutual Insurance Co. v. Steberger, 187 Wis. 2d 681, 523 N.W.2d 187 (Ct. App. 1994).

A medical insurer with subrogation rights may be an injured person under [former] sub. (4). An auto insurance policy providing that uninsured motorist coverage does not apply to persons claiming by right of subrogation impermissibly reduces coverage that the statute mandates for injured persons. WEA Insurance Corp. v. Freiheit, 190 Wis. 2d 111, 527 N.W.2d 363 (Ct. App. 1994).

No policy issued pursuant to the ch. 344 financial responsibility statutes may exclude coverage for persons related by blood or marriage to the operator as mandated by s. 632.32 (6) (b) 1. Bindrim v. Colonial Ins. Co. 190 Wis. 2d 525, 527 N.W.2d 321 (1995).

This section does not prevent the exclusion of coverage of vehicles used solely on the insured's premises. Rea v. Transportation Ins. Co. 191 Wis. 2d 271, 528 N.W.2d 79 (Ct. App. 1995).

This section does not distinguish between an owner and a named insurer. A policy that excludes coverage to the owner of a vehicle covered by the policy violates this section. Kettner v. Wausau Insurance Cos. 191 Wis. 2d 724, 530 N.W.2d 399 (Ct. App. 1995).

When the insurer defines uninsurance as including underinsurance, all case law concerning an insurer's duties and limitations in an uninsurance situation apply. Kuhn v. Allstate Ins. Co. 193 Wis. 2d 50, 532 N.W.2d 124 (1995).

An uninsured motorist policy that restricted coverage to cases when the insured is "hit" or "struck" was void. A bite by a dog tied in a parked vehicle was the result of use of the vehicle and subject to coverage. Trampf v. Prudential Property & Casualty Co. 199 Wis. 2d 380, 544 N.W.2d 596 (Ct. App. 1996), 95−0264.

Under the subrogation provision of [former] sub. (4) (b), there is no requirement that the insurer plead setoff or file a counterclaim in order to recover payments made to or on behalf of its insured. Jones v. Aetna Casualty & Surety Co. 212 Wis. 2d 165, 567 N.W.2d 904 (Ct. App. 1997), 96−1183.

When the named insured is a corporation, but the insurer knows the covered vehicles are owned by individuals and used by family members, this section does not distinguish between the owner of the vehicle and the named insured in determining coverage. Greene v. General Casualty Co. 216 Wis. 2d 152, 576 N.W.2d 56 (Ct. App. 1997), 96−2578.

[Former] sub. (4) does not prohibit the application of a policy arbitration clause to a disputed claim under the policy's uninsured motorist clause. Jones v. Poole, 217 Wis. 2d 116, 579 N.W.2d 739 (Ct. App. 1998), 97−1430.

Because a business operates under a variety of "d/b/a" designations and provides a spectrum of services, some of which qualify under sub. (5) (c) and some of which do not, does not operate to bar the coverage restrictions under that paragraph. That a policy names a "d/b/a" designation does not prevent looking to the entire legal entity to apply sub. (5) (c). Binon v. Great Northern Insurance Co. 218 Wis. 2d 26, 580 N.W.2d 370 (Ct. App. 1998), 97−0710.

Neither statutes nor case law expressly prohibit territorial limitations on uninsured motorist coverage. A clause restricting the territorial application of uninsured motorist coverage is valid. Clark v. American Family Mutual Insurance Co. 218 Wis. 2d 169, 577 N.W.2d 790 (1998), 97−0970.

No hit and run under [former] sub. (4) (a) 2. b. occurred when the insured's vehicle was struck by ice that dislodged from an unidentified truck as it passed. Dehnel v. State Farm Mutual Insurance Co. 231 Wis. 2d 14, 604 N.W.2d 575 (Ct. App. 1999), 98−3187.

[Former] sub. (4) required uninsured motorist coverage when a detached piece of an unidentified motor vehicle is propelled into the insured's motor vehicle by an unidentified motor vehicle. Theis v. Midwest Security Insurance Co. 2000 WI 15, 232 Wis. 2d 749, 606 N.W.2d 162, 98−2552.

Sub. (5) (j) allows "drive other car" exclusions in only very narrow and specific circumstances. It did not allow exclusion of uninsured motorist coverage for an insured injured while occupying a fire truck in the course of her employment. Blazekovic v. City of Milwaukee, 2000 WI 41, 234 Wis. 2d 587, 610 N.W.2d 467, 98−1821. See also Nischke v. Aetna Health Plans, 2008 WI App 190, 314 Wis. 2d 774, 763 N.W.2d 554, 08−0807.

Although only one parent was the named insured under an uninsured motorist insurance policy paying benefits for the wrongful death of their child, s. 895.04 requires payment of the proceeds to both parents. The purpose of the coverage is to reimburse the victim. If the victim is deceased the compensation must go to the victim's survivors, not to other insureds. Bruflat v. Prudential Property & Casualty Insurance Co. 2000 WI App 69, 233 Wis. 2d 523, 608 N.W.2d 371, 99−2049.

Neither sub. (6) nor s. 344.33 requires an automobile insurance policy to include motorcycle coverage. Beerbohm v. State Farm Mutual Automobile Insurance Co. 2000 WI App 105, 235 Wis. 2d 182, 612 N.W.2d 338, 99−1784.

No statute requires a self−insured entity under s. 344.16 to provide uninsured motorist coverage as part of the optional insurance it offers to its customers. Prophet v. Enterprise Rent−A−Car Company, Inc. 2000 WI App 171, 238 Wis. 2d 150, 617 N.W.2d 225, 99−0776.

A hit and run under [former] sub. (4) (a) 2. b. requires: 1) an unidentified motor vehicle that; 2) is involved in a "hit;" and 3) "runs" from the accident scene. Physical contact must be present. A hit and run occurs when an unidentified vehicle hits an intermediate vehicle, propelling it into the insured vehicle. Smith v. General Casualty Co. 2000 WI 127, 239 Wis. 2d 646, 619 N.W.2d 882, 98−1849.

This section applies only to policies issued and delivered in Wisconsin. Danielson v. Gasper, 2001 WI App 12, 240 Wis. 2d 633, 623 N.W.2d 182, 00−0950.

When underinsured motorist coverage in the amount of $25,000 was contracted for in violation of the requirement for $50,000 coverage under [former] sub. (4m) (d), the higher level of coverage was read into the policy under s. 631.15 (3m), even though it was not reflected in the premium paid. Brunson v. Ward, 2001 WI 89, 245 Wis. 2d 163, 629 N.W.2d 140, 98−3002.

The statute of limitations for subrogation claims under sub. (4) (a) 3. [now sub. (4) (c)] is the statute of limitations on the underlying tort. Schwittay v. Sheboygan Falls Mutual Insurance Co. 2001 WI App 140, 246 Wis. 2d 385, 630 N.W.2d 772, 00−2445.

Sub. (6) (a) was applicable to a general liability policy that contained an endorsement for non−owned liability coverage. Heritage Mutual Insurance Co. v. Wilber, 2001 WI App 247, 248 Wis. 2d 111, 635 N.W.2d 631, 01−0017.

An underinsured motorist provision that required the named insurer to be an occupant of an insured vehicle violated sub. (6) (b) 2. a. because the occupancy requirement had the effect of excluding coverage for a named insured. Mau v. North Dakota Insurance Reserve Fund, 2001 WI 134, 248 Wis. 2d 1031, 637 N.W.2d 45, 00−1369. See also Ruenger v. Soodsma, 2005 WI App 79, 281 Wis. 2d 228, 695 N.W.2d 840, 04−1795.

An underinsured motorist provision that required the named insurer to be an occupant of an insured vehicle was a "drive other car" exclusion under sub. (5) (j) because it had the effect of excluding coverage for a named insured not occupying the insured vehicle. Because the vehicle was a rental vehicle, it did not meet the requirement of sub. (5) (j) 1. that a vehicle subject to a permissible "drive other car" exclusion must be owned by a named insured or related party. Mau v. North Dakota Insurance Reserve Fund, 2001 WI 134, 248 Wis. 2d 1031, 637 N.W.2d 45, 00−1369.

For actions seeking coverage under an underinsured motorist policy, the statute of limitations begins to run from the date of loss, which is the date on which a final resolution is reached in the underlying claim against the tortfeasor, be it through denial of that claim, settlement, judgment, execution of releases, or other form of resolution, whichever is the latest. Yocherer v. Farmers Insurance Exchange, 2002 WI 41, 252 Wis. 2d 114, 643 N.W.2d 457, 00−0944.

Sub. (3) (b) does not extend policy–limits protection to both the tortfeasor and the person or persons vicariously liable for the tortfeasor's wrongdoing. A person to whom the negligence of another is imputed is not entitled to separate liability coverage. Folkman v. Quamme, 2003 WI 116, 264 Wis. 2d 571, 665 N.W.2d 857, 02–0261.

Sub. (6) (b) 2. a. only prohibits excluding coverage for certain individuals relating to the insured vehicle. An exclusion barring coverage for a non–owned vehicle is not prohibited. Gulmire v. St. Paul Fire and Marine Insurance Co., 2004 WI App 18, 269 Wis. 2d 501, 674 N.W.2d 629, 03–1199.

A self–insured city is not an insurer writing policies subject to [former] s. 632.32 (4m) (a) 1. and is not subject to the requirement to provide underinsured motorist coverage. Van Erden v. Sobczak, 2004 WI App 40, 271 Wis. 2d 163, 677 N.W.2d 718, 02–1595.

Sub. (3) extended coverage under an umbrella policy with an endorsement covering vehicles of the policy owners' daughter to include liability for an accident involving the daughter's car while being driven by a 3rd party with the daughter's permission. Dorbritz v. American Family Mutual Insurance Co., 2005 WI App 154, 284 Wis. 2d 442, 702 N.W.2d 406, 04–1896.

Sub. (3) (a) mandates that, except as provided in sub. (5), coverage provided to the named insured must apply in the same manner and under the same provisions to any person riding in any motor vehicle described in the policy. Sub. (3) (a) applies to uninsured motorist coverage, regardless of whether that coverage is categorized as liability or indemnity insurance. An insurer cannot cast its "other insurance" clause as an "exclusion" under subsection (5) (e) in order to save the clause from the requirements of subsection (3) (a). An "other insurance" clause that operated so that the policy provided primary coverage for a named insured while providing only excess coverage for an occupancy insured violated sub. (3) (a). Progressive Northern Insurance Co. v. Hall, 2006 WI 13, 288 Wis. 2d 282, 709 N.W.2d 46, 04–0688.

Neither sub. (3) (a) or (b) requires an insurance policy to provide separate limits of liability to both a person permissively using the covered vehicle and the named insured who is liable by statute for imputed negligence as a sponsor for a minor's driver license, for the minor's negligent operation of a vehicle. LaCount v. General Casualty Company of Wisconsin, 2006 WI 14, 288 Wis. 2d 358, 709 N.W.2d 418, 03–3258.

A full–service car wash where vehicles are serviced and driven by employees is a service station and therefore a statutory motor vehicle handler under sub. (2) (b). Rocker v. USAA Casualty Insurance Co., 2006 WI 26, 289 Wis. 2d 294, 711 N.W.2d 634, 04–0356.

The broad scope of the entire section is dependent upon whether a policy includes motor vehicle coverage, but each subsection can include provisions that exempt certain coverages from the scope as defined in sub. (1). An insurer cannot reduce the scope of the section simply because the motor vehicle coverage is issued as part of a comprehensive insurance policy. The statute can apply despite the fact that an insurer's policy excludes coverage for any vehicles owned by the insured, and no vehicles are specifically described in the policy. Under sub. (1), sub. (6) (a) applies to a policy that provides liability coverage for customers' automobiles while on or next to the premises. Rocker v. USAA Casualty Insurance Co., 2006 WI 26, 289 Wis. 2d 294, 711 N.W.2d 634, 04–0356.

Sub. (6) (b) 1. applies to underinsured motorist coverage when issued as part of a policy containing liability insurance. Vieau v. American Family Mutual Insurance Co., 2006 WI 31, 289 Wis. 2d 552, 712 N.W.2d 661, 04–1358.

When a tortfeasor injures more than one person in a single occurrence and the injured persons are not insured under the same underinsured motorist policy, a definition of an underinsured motor vehicle that compares the injured person's UIM limits to the limits of a tortfeasor's liability policy without regard to the amount the injured person actually receives from the tortfeasor's insurer is invalid under subs. (4m) [repealed 2009 Wis. Act 28, reenacted 2011 Wis. Act 14] and (5)(i). A UIM policy must provide a fixed level of UIM recovery that will be arrived at by combining payments made from all sources. Welin v. American Family Mutual Insurance Co., 2006 WI 81, 292 Wis. 2d 73, 717 N.W.2d 690, 04–1513.

The physical contact element for a hit–and–run accident under [former] sub. (4) (a) 2. b. requires: 1) a hit by the unidentified motor vehicle, or a part thereof, and 2) a hit to the insured's vehicle by another vehicle or part thereof, but not necessarily by the unidentified vehicle. DeHart v. Wisconsin Mutual Insurance Co., 2007 WI 91, 302 Wis. 2d 564, 734 N.W.2d 394, 05–2962.

Meyer instructs that a limitation on uninsured motorist (UM) coverage under a commercial policy does not violate [former] sub. (4) (a) as long as the restriction does not apply to the purchaser or policyholder, but only to its employees. There is nothing to indicate that the legislature sought to require UM coverage for employees under commercial fleet policies, whether the absence of coverage arises from the definition of the named insured, which did not include employees, or from the definition of "covered autos," which did not include employees' nonowned autos. Mittnacht v. St. Paul Fire and Casualty Insurance Co., 2009 WI App 51, 316 Wis. 2d 787, 767 N.W.2d 301, 08–1036.

"Motor vehicle described in the policy" under sub. (3) is not read to require the importation of a separate and broader definition of "covered auto" from a policy's liability insuring agreement into the policy's uninsured motorist insuring agreement. Mittnacht v. St. Paul Fire and Casualty Insurance Co., 2009 WI App 51, 316 Wis. 2d 787, 767 N.W.2d 301, 08–1036.

This section did not extend coverage to a rental car: 1) that the driver was not authorized to drive; 2) that he took without the express permission of either the owner of the car or the lessee of the car; 3) when the named insured in the insurance policy under which coverage was sought was not the owner of the car involved in the accident; and 4) when the adult resident who crashed the car was not a named insured under the insurance policy at issue. For the omnibus statute to require coverage, two factors must be met: 1) the rental vehicle must be a "motor vehicle described in the policy"; and 2) the use of the rental vehicle must be "for purposes and in the manner described in the policy." Neither fact was present. Venerable v. Adams, 2009 WI App 76, 318 Wis. 2d 784, 767 N.W.2d 386, 08–2188.

[Former] sub. (4) requires coverage when a detached piece of an unidentified motor vehicle is propelled into the insured's motor vehicle by an identified motor vehicle. There need not be first a "hit" and then a "run" for uninsured coverage. All that is required is that there be both a "hit" and a "run" (namely, a hit resulting from something done by the unidentified vehicle) in any sequence. Tomson v. American Family Mutual Insurance Co., 2009 WI App 150, 321 Wis. 2d 492, 775 N.W.2d 541, 08–2744.

A car–rental company issued a certificate of self–insurance under s. 344.16 and subject to liability limits under ss. 344.01 (2) (d) and 344.51 was not a self–insurer for purposes of an underinsured motorist clause that excluded coverage for a vehicle owned or operated by a "self–insurer." Bethke v. Auto–Owners Insurance Co., 2013 WI 16, 345 Wis. 2d 533, 825 N.W.2d 482, 10–3153.

During the two–year period when both s. 632.32 (5) (j) and (6) (d), 2009 stats., authorizing certain "drive other car" exclusions and prohibiting antistacking provisions in uninsured motorist (UM) coverage were in force, "drive other car" exclusions could not prevent stacking of UM coverage limits for up to three vehicles owned by the same insured. Belding v. Demoulin, 2013 WI App 26, 346 Wis. 2d 160, 828 N.W.2d 890, 12–0829.

Affirmed. 2014 WI 8, 352 Wis. 2d 359, 843 N.W.2d 373, 12–0829.

When the insurer in this case: 1) required its insured to maintain a liability policy to receive coverage under an excess policy; 2) granted all permissive users coverage in its "Wisconsin Endorsement;" and then 3) excluded all those same permissive users from coverage based upon coverage under the liability policy under an other–insurance clause, it violated sub. (5) (c) and rendered the Wisconsin Endorsement illusory. Hernandez v. Liberty Mutual Insurance Co., 2014 WI App 36, 353 Wis. 2d 730, 844 N.W.2d 657, 13–1286.

A person getting ready to direct a driver where to go is not using the vehicle. In determining who constitutes a user of a vehicle for the purposes of an omnibus clause, it is generally required that if one who claims to be a user was not actually driving the vehicle, that individual must have exercised some form of control over it. Jackson v. Wisconsin County Mutual Insurance Corp., 2014 WI 36, 354 Wis. 2d 327, 847 N.W.2d 384, 12–1644.

The common law definition of intra–policy stacking requiring a separate premium attributable to each vehicle in an insurance policy was applicable to sub. (6) (d) as it existed between 2009 and 2011. Bodish v. West Bend Mutual Insurance Co., 2014 WI App 78, 355 Wis. 2d 392, 851 N.W.2d 811, 13–1659.

As used in sub. (2) (d), 2009 stats., the phrase "legally entitled to recover" means recovery that exceeds what insureds can actually recover from tortfeasors. The phrase does not thwart underinsured motorist coverage for an insured who has not been fully compensated for his or her damages when the amount of damages an insured could actually recover from a tortfeasor is capped by statute. State Farm Mutual Automobile Ins. Co. v. Hunt, 2014 WI App 115, 358 Wis. 2d 379, 856 N.W.2d 633, 13–2518.

An exclusion of passengers of an insured's vehicle from a policy's underinsured motorist coverage when the insured driver was at fault and was operating a vehicle insured by the policy's liability coverage, although potentially in violation of sub. (6) (b) 2., was enforceable under the savings provision in sub. (5) (e) that "exclusions are effective even if incidentally to their main purpose they exclude persons, uses or coverages that could not be directly excluded under sub. (6) (b)." Pierce v. Mid–Century Insurance Co., 2016 WI App 79, 372 Wis. 2d 171, 887 N.W.2d 115, 15–2408.

You Get What You Pay For: Why Wisconsin Should Adopt Uninsured and Underinsured Motorist Stacking Waivers. Kempke. 2016 WLR 411.

Uninsured motorists coverage: Wisconsin courts open up additional avenues of recovery. Dunphy. WBB Nov. 1982.

Politics & Wisconsin Automobile Insurance Law. Jaskulski. Wis. Law. Nov. 2010.

Wisconsin's New Automobile Insurance Law. End. Wis. Law. Oct. 2011.

632.34 Defense of noncooperation. If a policy of automobile liability insurance provides a defense to the insurer for lack of cooperation on the part of the insured, the defense is not effective against a 3rd person making a claim against the insurer unless there was collusion between the 3rd person and the insured or unless the claimant was a passenger in or on the insured vehicle. If the defense is not effective against the claimant, after payment the insurer is subrogated to the injured person's claim against the insured to the extent of the payment and is entitled to reimbursement by the insured.

History: 1975 c. 375, 421; 1979 c. 102, 104, 177.

Legislative Council Note, 1979: This provision is continued from former s. 632.34 (8). It is changed from a required provision of the policy to a rule of law. It is not the kind of rule that needs to be put in the policy to inform the policyholder. Indeed, the policyholder should receive no encouragement to fail to cooperate. This is a relaxation of present law. [Bill 146–S]

Prejudice is not a component of the defense of noncooperation. Schaefer v. Northern Assurance Co. 182 Wis. 2d 148, 513 N.W.2d 16 (Ct. App. 1994).

In *Schaefer*, the Wisconsin Court of Appeals confirmed that this section had abrogated the common–law requirement of prejudice in non–cooperation cases, but this was true only for cases involving automobiles, to which this section expressly applies. Welton Enterprises, Inc. v. Cincinnati Ins. Co. 131 F. Supp. 3d 827 (2015).

632.35 Prohibited rejection, cancellation and nonrenewal. No insurer may cancel or refuse to issue or renew an automobile insurance policy wholly or partially because of one or more of the following characteristics of any person: age, sex, residence, race, color, creed, religion, national origin, ancestry, marital status or occupation.

History: 1975 c. 375; 1979 c. 102.

632.36 Accident in the course of business or employment. (1) RATE AND OTHER TERMS. An insurer may increase or charge a higher rate for a motor vehicle liability insurance policy issued or renewed on or after April 16, 1982, on the basis of an accident which occurs while the insured is operating a motor vehi-

cle in the course of the insured's business or employment, only if the policy covers the insured for liability arising in the course of the insured's business or employment. An insurer may issue or renew a motor vehicle liability insurance policy on or after November 1, 1989, on terms that are less favorable to the insured than would otherwise be offered, including but not limited to the rate, because of an accident which occurs while the insured is operating a motor vehicle in the course of the insured's business or employment, only if the policy covers the insured for liability arising in the course of the insured's business or employment.

(2) CANCELLATION OR NONRENEWAL. An insurer may cancel a motor vehicle liability insurance policy that is issued or renewed on or after November 1, 1989, or refuse to renew a motor vehicle liability insurance policy on or after November 1, 1989, on the basis of an accident which occurs while the insured is operating a motor vehicle in the course of the insured's business or employment, only if the policy covers the insured for liability arising in the course of the insured's business or employment.

History: 1981 c. 178; 1989 a. 31.

632.365 Use of emission inspection data in setting rates. An insurer may not use odometer reading data collected in the course of an inspection under s. 110.20 (6) or (7) as a factor in setting rates or premiums for a motor vehicle liability insurance policy or as a factor in altering rates or premiums during the term, or at renewal, of such a policy. However, an insurer may use such data as a basis for investigation into the number of miles that the motor vehicle is normally driven.

History: 1991 a. 279; 1993 a. 213.

632.37 Motor vehicle glass repair practices; restriction on specifying vendor. An insurer that issues a motor vehicle insurance policy covering the repair or replacement of motor vehicle glass may not require, as a condition of that coverage, that an insured, or a 3rd party, making a claim under the policy for the repair or replacement of motor vehicle glass obtain services or parts from a particular vendor, or in a particular location, specified by the insurer.

History: 1991 a. 269.

632.375 Motor vehicle repair practices; restriction on specifying vendor. (1) SCOPE. This section applies to every insurer that issues or delivers in this state a motor vehicle insurance policy that covers repairs to a motor vehicle registered or principally garaged in this state.

(2) PROHIBITED PRACTICES. (a) No insurer may require that, as a condition of the coverage specified in sub. (1), repairs to a motor vehicle must be made by a particular contractor or repair facility. For purposes of this section, a consumer has the right to select the motor vehicle repair facility of his or her choice.

(b) No insurer may fail to initiate and conclude with due dispatch an investigation of a claim for repairs to a motor vehicle on the basis of whether the repairs will be made by a particular contractor or repair facility.

(3) INAPPLICABILITY TO GLASS REPAIR. Section 632.37, rather than this section, applies to the repair or replacement of motor vehicle glass under a motor vehicle insurance policy.

History: 2015 a. 93.

632.38 Nonoriginal manufacturer replacement parts. (1) DEFINITIONS. In this section:

(a) "Insured" means the person who owns the motor vehicle that is subject to repair or the person seeking the repair on behalf of the owner.

(b) "Insurer's representative" means a person, excluding the person repairing the motor vehicle, who has agreed in writing to represent an insurer with respect to a claim.

(c) "Motor vehicle" means any motor–driven vehicle required to be registered under ch. 341 or exempt from registration under s. 341.05 (2), including a demonstrator or executive vehicle not titled or titled by a manufacturer or a motor vehicle dealer. "Motor vehicle" does not mean a moped, semitrailer or trailer designed for use in combination with a truck or truck tractor.

(d) "Nonoriginal manufacturer replacement part" means a replacement part that is not made by or for the manufacturer of an insured's motor vehicle.

(e) "Replacement part" means a replacement for any of the nonmechanical sheet metal or plastic parts that generally constitute the exterior of a motor vehicle, including inner and outer panels.

(2) NOTICE OF INTENDED USE. An insurer or the insurer's representative may not require directly or indirectly the use of a nonoriginal manufacturer replacement part in the repair of an insured's motor vehicle, unless the insurer or the insurer's representative provides to the insured the notice described in this subsection in the manner required in sub. (3) or (4). The notice shall be in writing and shall include all of the following information:

(a) A clear identification of each nonoriginal manufacturer replacement part that is intended for use in the repair of the insured's motor vehicle.

(b) The following statement in not smaller than 10–point type: "This estimate has been prepared based on the use of one or more replacement parts supplied by a source other than the manufacturer of your motor vehicle. Warranties applicable to these replacement parts are provided by the manufacturer or distributor of the replacement parts rather than by the manufacturer of your motor vehicle."

(3) DELIVERY OF NOTICE. (a) The notice described in sub. (2) shall appear on or be attached to the estimate of the cost of repairing the insured's motor vehicle if the estimate is based on the use of one or more nonoriginal manufacturer replacement parts and is prepared by the insurer or the insurer's representative. The insurer or the insurer's representative shall deliver the estimate and notice to the insured before the motor vehicle is repaired.

(b) If the insurer or the insurer's representative directs the insured to obtain one or more estimates of the cost of repairing the insured's motor vehicle and the estimate approved by the insurer or the insurer's representative clearly identifies one or more nonoriginal manufacturer replacement parts to be used in the repair, the insurer or the insurer's representative shall assure delivery of the notice described in sub. (2) to the insured before the motor vehicle is repaired.

(c) The insurer or the insurer's representative may not require the person repairing the motor vehicle to give the notice described in sub. (2).

(d) Notwithstanding par. (b), if an insured authorizes repairs to begin prior to the approval by the insurer or the insurer's representative of an estimate that clearly identifies one or more nonoriginal manufacturer replacement parts to be used in the repair, the insurer or the insurer's representative shall send the written notice described in sub. (2) by mail to the insured's last–known address no later than 3 working days after the insurer or the insurer's representative receives the estimate.

(4) NOTICE BY TELEPHONE. Notwithstanding sub. (3), notice of the intention to use nonoriginal manufacturer replacement parts in the repair of the insured's motor vehicle may be given by the insurer or the insurer's representative by telephone. If such notice is given, the insurer or insurer's representative shall send the written notice described in sub. (2) by mail to the insured's last–known address no later than 3 working days after the telephone contact.

History: 1991 a. 176.

SUBCHAPTER V

LIFE INSURANCE AND ANNUITIES

Cross–reference: See also ch. Ins 2, Wis. adm. code.

632.41 Prohibited provisions in life insurance. (1) ASSESSABLE POLICIES. No insurer may issue assessable life

insurance policies under which assessments or calls may be made upon policyholders or others.

(2) BURIAL INSURANCE. Except as provided in s. 632.415, no contract in which the insurer agrees to provide benefits to pay for any of the incidents of burial or other disposition of the body of a deceased may provide that the benefits are payable to a funeral director or any other person doing business related to burials.

History: 1975 c. 373, 375, 422; 1979 c. 102; 1995 a. 295; 1999 a. 191.

Cross–reference: See also ch. Ins 23, Wis. adm. code.

Sub. (2) does not prohibit naming funeral director as beneficiary of life insurance policy in conjunction with separate agreement between insured and funeral director that proceeds will be used for funeral and burial expenses. 71 Atty. Gen. 7.

Purpose of (2) is to prevent monopolistic or unfair trade practices. 76 Atty. Gen. 291.

632.415 Funeral policies. (1) In this section, "multipremium funeral policy" means a life insurance policy sold under sub. (2) for which premiums to fund the policy are paid over time.

(2) A life insurance policy may provide for the assignment of the proceeds of the policy to a funeral director or operator of a funeral establishment if the insurance intermediary who sells or solicits the sale of the policy is not an agent of the funeral director or operator of the funeral establishment or if the assignment of proceeds is contingent on the provision of funeral merchandise or funeral services as provided for in a burial agreement that satisfies the requirements of s. 445.125 (3m) and rules promulgated by the funeral directors examining board under s. 445.125 (3m) (j) 1. b.

(3) A life insurance policy sold under sub. (2) shall permit the policyholder to designate a different beneficiary, upon written notice to the insurer, and a different funeral director or operator of a funeral establishment that is to receive the assignment of proceeds, after written notice to the current funeral director or operator of the funeral establishment.

(4) (a) An insurer may issue a multipremium funeral policy only if, at the time that the policy is issued, the face amount of the policy is not less than the value of funeral merchandise and services to be provided under a burial agreement under s. 445.125 (3m).

(b) The death benefit under a multipremium funeral policy may not be less than the face amount of the policy unless all of the following apply:

1. The policy contains a detailed explanation of the lower death benefit, as well as full disclosure of the lower death benefit on the first page of the policy.

2. The applicant does not apply for, or qualify for, any full face amount multipremium funeral policy that the insurer offers.

3. The death benefit is not less than at least one of the following:

a. Twenty–five percent of the face amount of the policy during the first year that the policy is in effect, 50 percent of the face amount of the policy during the 2nd year that the policy is in effect and the full face amount of the policy after the end of the 2nd year that the policy is in effect, but in no event less than the total of the premiums actually paid.

b. During the first 2 years that the policy is in effect, an amount equal to the actual premiums paid plus simple interest at the rate of 3 percent per year, and, after the end of the 2nd year that the policy is in effect, the full face amount of the policy.

(c) The period over which premiums may be payable under a multipremium funeral policy may not exceed the following applicable period:

1. Twenty years, if the insured is less 60 years of age when the policy is issued.

2. Ten years, if the insured is at least 60 years of age but less than 80 years of age when the policy is issued.

3. Five years, if the insured is at least 80 years of age when the policy is issued.

(d) At the time that an applicant applies for coverage under a multipremium funeral policy, the insurance intermediary or other person selling or soliciting the sale of the policy shall disclose the maximum number of premium payments to be made over the life of the policy, the frequency of the premium payments and the amount of each premium payment.

(4m) Proof of death for an insurance policy sold under sub. (2) may be established with an affidavit in the form prescribed under s. 69.02 (1) (c) if the insurer consents to receipt of the affidavit.

(5) Subject to subs. (3) and (4), the commissioner shall by rule establish minimum standards for claims payments, marketing practices and reporting practices for life insurance policies sold under sub. (2).

History: 1999 a. 191 ss. 2 to 5; 2003 a. 167.

Cross–reference: See also ch. Ins 23, Wis. adm. code.

632.42 Trustee and deposit agreements in life insurance. (1) TRUSTEE AND OTHER AGREEMENTS. An insurer may hold as a part of its general assets the proceeds of any policy subject to this subchapter under a trust or other agreement upon such terms and restrictions as to revocation by the policyholder and control by the beneficiary and with such exemptions from the claims of creditors of the beneficiary as the insurer and the policyholder agree to in writing. An insurer may also receive funds in such amounts and upon such conditions, including the right of the policyholder to withdraw unused portions thereof, as the insurer and the policyholder agree to in writing:

(a) *Advance premiums.* As premiums in advance upon policies or annuities subject to this subchapter; or

(b) *New policies.* To accumulate for the purchase of future policies or annuities subject to this subchapter.

(2) ACCUMULATION OF FUNDS. Any insurer may, in connection with life insurance or annuity contracts, accept funds remitted to it under an agreement for an accumulation of the funds for the purpose of providing annuities or other benefits, under such reasonable rules as are prescribed by the commissioner.

History: 1975 c. 373, 375, 422.

632.43 Standard nonforfeiture law for life insurance. (1) On and after January 1, 1948, no policy of life insurance, except as stated in sub. (8), shall be issued or delivered in this state unless it shall contain in substance the following provisions, or corresponding provisions which in the opinion of the commissioner are at least as favorable to the defaulting or surrendering policyholder as the minimum requirements under this section and are substantially in compliance with sub. (7m):

(a) In the event of default in any premium payment, the company will grant, upon proper request not later than 60 days after the due date of the premium in default, a paid–up nonforfeiture benefit on a plan stipulated in the policy, effective as of the due date, of an amount specified in this section or an actuarially equivalent paid–up nonforfeiture benefit which provides a greater amount or longer period of death benefits or a greater amount or earlier payment of endowment benefits.

(b) Upon surrender of the policy within 60 days after the due date of any premium payment in default after premiums have been paid for at least 3 full years in the case of ordinary insurance or 5 full years in the case of industrial insurance, the company will pay, in lieu of any paid–up nonforfeiture benefit, a cash surrender value of such amount as may be hereinafter specified.

(c) A specified paid–up nonforfeiture benefit shall become effective as specified in the policy unless the person entitled to make such election elects another available option not later than 60 days after the due date of the premium in default.

(d) If the policy shall have become paid up by completion of all premium payments or if it is continued under any paid–up nonforfeiture benefit which became effective on or after the third policy anniversary in the case of ordinary insurance or the fifth policy anniversary in the case of industrial insurance, the company will pay, upon surrender of the policy within 30 days after any policy anniversary, a cash surrender value of such amount as may be hereinafter specified.

(e) For policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, a statement of the mortality table, interest rate, and method used in calculating cash surrender values and the paid–up nonforfeiture benefits available under the policy. For other policies, a statement of the mortality table and interest rate used in calculating the cash surrender values and the paid–up nonforfeiture benefits available under the policy and a table showing any cash surrender value or paid–up nonforfeiture benefit available under the policy on each policy anniversary during the shorter of the first 20 policy years or the term of the policy assuming that there are no dividends or paid–up additions credited to the policy and that there is no indebtedness to the company on the policy.

(f) A statement that the cash surrender values and the paid–up nonforfeiture benefits available under the policy are not less than the minimum values and benefits required by or pursuant to the insurance law of the state in which the policy is delivered; an explanation of the manner in which the cash surrender values and the paid–up nonforfeiture benefits are altered by the existence of any paid–up additions credited to the policy or any indebtedness to the company on the policy; if a detailed statement of the method of computation of the values and benefits shown in the policy is not stated therein, a statement that such method of computation has been filed with the insurance supervisory official of the state in which the policy is delivered; and a statement of the method to be used in calculating the cash surrender value and paid–up nonforfeiture benefit available under the policy on any policy anniversary beyond the last anniversary for which such values and benefits are consecutively shown in the policy.

(g) The company shall reserve the right to defer the payment of any cash surrender value for a period of 6 months after demand therefor with surrender of the policy.

(h) Any of the foregoing provisions or portions thereof not applicable by reason of the plan of insurance may, to the extent inapplicable, be omitted from the policy.

(2) (a) Any cash surrender value under the policy on default of a premium payment due on any policy anniversary shall be not less than any excess of the then present value of any existing paid–up additions and future guaranteed benefits which would have been provided by the policy, if there had been no default, over the sum of the present value of the adjusted premiums under subs. (4) to (6m) corresponding to premiums which would have fallen due on and after the anniversary and the amount of any indebtedness to the company on the policy.

(b) For a policy issued on or after the operative date of sub. (6m) providing by rider or supplemental provision supplemental life insurance or annuity benefits at the option of the insured on payment of an additional premium, any cash surrender value under the policy on default of a premium payment due on a policy anniversary shall be not less than the sum of the following:

1. The cash surrender value under par. (a) for the policy without the rider or supplemental provision.

2. The cash surrender value under par. (a) for a policy providing only the benefits of the rider or supplemental provision.

(c) For a family policy issued on or after the operative date of sub. (6m) providing term insurance on the life of the spouse of the primary insured expiring before the spouse attains the age of 71, any cash surrender value under the policy on default of a premium payment due on a policy anniversary shall be not less than the sum of the following:

1. The cash surrender value under par. (a) for the policy without the term insurance on the life of the spouse.

2. The cash surrender value under par. (a) for a policy providing only the benefits of the term insurance on the life of the spouse.

(d) Any cash surrender value available within 30 days after any policy anniversary under any policy paid–up by completion of all premium payments or any policy continued under any paid–up nonforfeiture benefit shall be not less than the then present value of any existing paid–up additions and future guaranteed benefits provided by the policy decreased by any indebtedness to the company on the policy.

(3) Any paid–up nonforfeiture benefit available under the policy in the event of default in a premium payment due on any policy anniversary shall be such that its present value as of such anniversary shall be at least equal to the cash surrender value then provided for by the policy or, if none is provided for, that cash surrender value which would have been required by this section in the absence of the condition that premiums shall have been paid for at least a specified period.

(4) (a) Except as provided in sub. (5) (b), the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding any extra premiums charged because of impairments or special hazards, that the present value, at the date of issue of the policy, of all adjusted premiums shall be equal to the sum of all of the following:

1. The then present value of the future guaranteed benefits provided for by the policy.

2. Two percent of the amount of insurance, if the insurance is uniform in amount, or of the equivalent uniform amount, as defined in sub. (5), if the amount of insurance varies with duration of the policy.

3. Forty percent of the adjusted premium for the first policy year.

4. Twenty–five percent of either the adjusted premium for the first policy year or the adjusted premium for a whole life policy of the same uniform or equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance, whichever is less.

(b) In applying the percentages specified in par. (a) 3. and 4., no adjusted premium shall be considered to exceed 4 percent of the amount of insurance or uniform amount equivalent thereto. The date of issue of a policy for the purpose of this subsection and sub. (5) shall be the date as of which the rated age of the insured is determined.

(5) (a) In the case of a policy providing an amount of insurance varying with duration of the policy, the equivalent uniform amount thereof for the purpose of sub. (4) and this subsection shall be deemed to be the uniform amount of insurance provided by an otherwise similar policy, containing the same endowment benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at the date of issue as the benefits under the policy; provided, that in the case of a policy providing a varying amount of insurance issued on the life of a child under age 10, the equivalent uniform amount may be computed as though the amount of insurance provided by the policy prior to the attainment of age 10 were the amount provided by such policy at age 10.

(b) The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall be equal to: A) the adjusted premiums for an otherwise similar policy issued at the same age without such term insurance benefits, increased, during the period for which premiums for such term insurance benefits are payable, by B) the adjusted premiums for such term insurance, the foregoing items A) and B) being calculated separately and as specified in par. (a) and sub. (4) except that, for the purposes of sub. (4) (a) 2., 3. and 4., the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in B) shall be equal to the excess of the corresponding amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in A).

(6) (a) Except as otherwise provided in par. (b) or (c), all adjusted premiums and present values referred to in this section shall for all policies of ordinary insurance be calculated on the

basis of the commissioners 1941 standard ordinary mortality table, except that for any category of ordinary insurance issued on female risks adjusted premiums and present values may be calculated according to an age not more than 3 years younger than the actual age of the insured, and such calculations for all policies of industrial insurance shall be made on the basis of the 1941 standard industrial mortality table. All calculations shall be made on the basis of the rate of interest, not exceeding 3.5 percent per year, specified in the policy for calculating cash surrender values and paid–up nonforfeiture benefits; provided, that in calculating the present value of any paid–up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may not be more than 130 percent of the rates of mortality according to such applicable table. For insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the commissioner.

(b) In the case of ordinary policies issued on or after the operative date of this paragraph, all adjusted premiums and present values referred to in this section shall be calculated on the basis of the commissioners 1958 standard ordinary mortality table and the rate of interest, not exceeding 3.5 percent per year, specified in the policy for calculating cash surrender values and paid–up nonforfeiture benefits, provided that for any category of ordinary insurance issued on female risks adjusted premiums and present values may be calculated according to an age not more than 6 years younger than the actual age of the insured. In calculating the present value of any paid–up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the commissioners 1958 extended term insurance table. For insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the commissioner. After June 14, 1959, any company may file with the commissioner a written notice of its election to comply with the provisions of this paragraph after a specified date before January 1, 1966. After the filing of such notice, then upon such specified date, which shall be the operative date of this paragraph for such company, this paragraph shall become operative with respect to the ordinary policies thereafter issued by such company. If a company makes no such election, the operative date of this paragraph for such company shall be January 1, 1966.

(c) In the case of industrial policies issued on or after the operative date of this paragraph as defined herein, all adjusted premiums and present values referred to in this section shall be calculated on the basis of the commissioners 1961 standard industrial mortality table and the rate of interest, not exceeding 3.5 percent per year, specified in the policy for calculating cash surrender values and paid–up nonforfeiture benefits; provided, that in calculating the present value of any paid–up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the commissioners 1961 industrial extended term insurance table, and for insurance issued on a substandard basis, the calculations of any such adjusted premiums and present values may be based on such other table of mortality as is specified by the company and approved by the commissioner. After May 19, 1963, any company may file with the commissioner a written notice of its election to comply with this paragraph after a specified date before January 1, 1968. After the filing of such notice, then upon such specified date, which shall be the operative date of this paragraph for such company, this paragraph shall become operative with respect to the industrial policies thereafter issued by such company. If a company makes no such election, the operative date of this paragraph for such company shall be January 1, 1968.

(d) A rate of interest not exceeding 5.5 percent per year may be used for ordinary policies or industrial policies, or both, issued on or after June 19, 1974, in lieu of the rate referred to in pars. (b) and (c).

(6m) (a) In this subsection:

1. "Additional expense allowance" means the sum of the following:

a. One percent of any positive excess of the average amount of insurance at the beginning of each of the first 10 policy years after an unscheduled change in benefits or premiums, over the average amount of insurance before the change at the beginning of each of the first 10 policy years after the next most recent change or date of issue, if there was no previous change.

b. One–hundred twenty–five percent of any positive increase in the nonforfeiture net level premium.

2. "Date of issue" means the date as of which the rated age of the insured is determined.

3. "Nonforfeiture interest rate" means either of the following:

a. For all policies other than those described in subd. 3. b., 125 percent of the applicable calendar year valuation interest rate under s. 623.06 rounded to the nearest 0.25 percent, but in no case less than 4 percent.

b. For policies issued on or after the operative date of the valuation manual, the rate per annum provided in the valuation manual.

4. "Nonforfeiture net level premium" means the present value at the date of issue of the guaranteed benefits provided by a policy divided by the present value at the date of issue of an annuity of one per year payable on the date of issue and each policy anniversary on which a premium is due.

4m. "Operative date of the valuation manual" has the meaning given in s. 623.06 (1) (f).

5. "Premiums" do not include amounts payable as extra premiums to cover impairments or special hazards or a uniform annual contract charge or policy fee specified in the policy in the method to be used in calculating cash surrender values and paid–up nonforfeiture benefits.

(b) Except as provided under par. (d), adjusted premiums shall be calculated on an annual basis and shall be such a uniform percentage of the future premiums specified in the policy for each policy year that the present value at the date of issue of the adjusted premiums is equal to the sum of the following:

1. The present value at the date of issue of the future guaranteed benefits provided by the policy.

2. One percent of any uniform amount of insurance or one percent of the average amount of insurance at the beginning of each of the first 10 policy years.

3. One–hundred twenty–five percent of the nonforfeiture net level premium. For purposes of this subdivision, the nonforfeiture net level premium shall not exceed 4 percent of any uniform amount of insurance or 4 percent of the average amount of insurance at the beginning of each of the first 10 policy years.

(c) For policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums or which provide an option for changes in benefits or premiums other than a change to a new policy:

1. The adjusted premiums and present values shall at the date of issue be calculated on the assumption that future benefits and premiums do not change and at the time of the change the future adjusted premiums, nonforfeiture net level premiums and present value shall be recalculated on the assumption that future benefits and premiums do not undergo further change.

2. Except as provided under par. (d), the recalculated future adjusted premiums for the policy shall be such a uniform percentage of the future premiums specified in the policy for each policy

year that the present value at the time of the change of the adjusted premiums is equal to the excess of the sum of the present value at the time of the change of the future guaranteed benefits provided by the policy and any additional expense allowance over any cash surrender value at the time of the change or present value at the time of the change of any paid−up nonforfeiture benefit.

3. The recalculated nonforfeiture net level premium is equal to the sum of the nonforfeiture net level premium applicable before the change multiplied by the present value of an annuity of one per year payable on each anniversary of the policy on or after the date of the change on which a premium would have fallen due had the change not occurred, and the present value at the time of the change of the increase in future guaranteed benefits provided by the policy, divided by the present value at the time of the change of an annuity of one per year payable on each anniversary of the policy on or after the date of change on which a premium falls due.

(d) For a policy issued on a substandard basis which provides reduced graded amounts of insurance so that, in each policy year, the policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis which provides higher uniform amounts of insurance, adjusted premiums and present values for the substandard policy may be calculated as if it were issued to provide the higher uniform amounts of insurance on the standard basis.

(e) All adjusted premiums and present values under this section shall be calculated on the following bases:

1. For ordinary insurance policies, the commissioners 1980 standard ordinary mortality table or, at the election of the company for any one or more specified plans of life insurance, the commissioners 1980 standard ordinary mortality table with 10−year select mortality factors.

2. For industrial insurance policies, the commissioners 1961 standard industrial mortality table.

3. For policies issued in a calendar year, a rate of interest not exceeding the nonforfeiture interest rate for policies issued in that calendar year, except that:

a. At the option of the company, calculations for all policies issued in a calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate for policies issued in the immediately preceding calendar year.

b. Under any paid−up nonforfeiture benefit or any paid−up dividend addition, any cash surrender value available shall be calculated on the basis of the mortality table and rate of interest used in determining the amount of the paid−up nonforfeiture benefit or paid−up dividend additions.

c. A company may calculate the amount of any guaranteed paid−up nonforfeiture benefit or any paid−up addition on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values.

d. In calculating the present value of any paid−up term insurance with any accompanying pure endowment offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those in the commissioners 1980 extended term insurance table for policies of ordinary insurance and not more than those in the commissioners 1961 industrial extended term insurance table for policies of industrial insurance.

e. For insurance issued on a substandard basis, the calculation of adjusted premiums and present values may be based on appropriate modifications of those tables.

f. For policies issued before the operative date of the valuation manual, any ordinary mortality tables adopted after 1980 by the National Association of Insurance Commissioners, that are approved by rule adopted by the commissioner for use in determining the minimum nonforfeiture standard, may be substituted for the commissioners 1980 standard ordinary mortality table with or without 10−year select mortality factors or for the commissioners 1980 extended term insurance table. For policies issued on or after the operative date of the valuation manual, the valuation manual provides the commissioners standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the commissioners 1980 standard ordinary mortality table with or without 10−year select mortality factors or for the commissioners 1980 extended term insurance table. If the commissioner approves, by rule, any ordinary mortality table adopted by the National Association of Insurance Commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual.

g. For policies issued before the operative date of the valuation manual, any industrial mortality tables adopted after 1980 by the National Association of Insurance Commissioners, that are approved by rule adopted by the commissioner for use in determining the minimum nonforfeiture standard, may be substituted for the commissioners 1961 standard industrial mortality table or the commissioners 1961 industrial extended term insurance table. For policies issued on or after the operative date of the valuation manual, the valuation manual provides the commissioners standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the commissioners 1961 standard industrial mortality table or for the commissioners 1961 industrial extended term insurance table. If the commissioner approves, by rule, any industrial mortality table adopted by the National Association of Insurance Commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual.

(f) Any refiling of nonforfeiture values or their methods of computation for any previously approved policy form which involves only a change in the interest rate or mortality table used to compute nonforfeiture values does not require refiling of any other provisions of that policy form.

(g) This subsection applies to all policies issued on or after the operative date under par. (h) and subs. (4) to (6) do not apply to policies issued on or after the operative date under par. (h).

(h) After May 1, 1982, any company may file with the commissioner a written notice of its election to comply with this subsection after a specified date before January 1, 1989, which shall be the operative date of this subsection for the company. If a company makes no election, the operative date of this subsection for the company is January 1, 1989.

(6t) (a) In this subsection, "plan" means a plan of life insurance:

1. Providing for premiums based on recent estimates of future experience available on or near a premium due date; or

2. For which the minimum nonforfeiture values cannot be determined under this section.

(b) No plan may be issued in this state unless the commissioner determines that:

1. The benefits and pattern of premiums do not mislead prospective policyholders or insureds; and

2. The benefits are substantially as favorable to policyholders and insureds as the minimum benefits required under this section.

(c) The commissioner shall by rule adopt a method consistent with the principles of this section for determining the minimum cash surrender values and paid−up nonforfeiture benefits provided by a plan.

(7) Any cash surrender value and any paid−up nonforfeiture benefit, available under the policy in the event of default in a premium payment due at any time other than on the policy anniversary, shall be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary. All values under subs. (2) to (6m) may be calculated upon the assumption that any death benefit is payable at the end of the policy year of death. The net value of any paid−up additions, other than paid−up term additions, shall be not less than

the amounts used to provide the additions. Notwithstanding sub. (2), additional benefits payable in the event of death or dismemberment by accident or accidental means, in the event of total and permanent disability, as reversionary annuity or deferred reversionary annuity benefits, as term insurance benefits provided by a rider or supplemental policy provision to which, if issued as a separate policy, this section would not apply, as term insurance on the life of a child or on the lives of children provided in a policy on the life of a parent of the child, if the term insurance expires before the child's age is 26, is uniform in amount after the child's age is one, and has not become paid up by reason of the death of a parent of the child, and as other policy benefits additional to life insurance and endowment benefits, and premiums for all of these additional benefits, shall be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by this section, and none of these additional benefits may be required to be included in any paid–up nonforfeiture benefits.

(7m) (a) This subsection applies to all policies issued on or after January 1, 1984. Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary shall be in an amount which does not differ by more than 0.2 percent of any uniform amount of insurance or 0.2 percent of the average amount of insurance at the beginning of each of the first 10 policy years, from the sum of the following:

1. The greater of zero and the basic cash value under par. (b) on the policy anniversary.

2. The present value of any existing paid–up additions less the amount of any indebtedness to the company under the policy.

(b) The basic cash value is the present value of the future guaranteed benefits which would have been provided for by the policy, excluding any existing paid–up additions and before deduction of any indebtedness to the company, if there had been no default, less the present value on the policy anniversary of the nonforfeiture factors under par. (c) corresponding to premiums which would have fallen due on and after the policy anniversary. The effects on the basic cash value of supplemental life insurance or annuity benefits or of family coverage under subs. (2) or (4) to (6) shall be the same as the effects under subs. (2) or (4) to (6) on the cash surrender values under those subsections.

(c) The nonforfeiture factor for each policy year is an amount equal to a percentage of the adjusted premium under subs. (4) to (6m) for the policy year. Except as provided under par. (d), the percentage:

1. Must be the same for each policy year between the 2nd policy anniversary and the later of the 5th policy anniversary and the first policy anniversary at which there is available a cash surrender value, before including any paid–up additions and before deducting any indebtedness, of at least 0.2 percent of any uniform amount of insurance or 0.2 percent of the average amount of insurance at the beginning of each of the first 10 policy years; and

2. Must apply to at least 5 consecutive policy years after the latest of the policy anniversaries under subd. 1.

(d) No basic cash value may be less than the value which would be obtained if the adjusted premiums for the policy under sub. (6m) were substituted for the nonforfeiture factors in the calculation of the basic cash value.

(e) All adjusted premiums and present values under this subsection shall be calculated on the mortality and interest bases applicable to the policy under this section. The cash surrender values under this subsection include any endowment benefits provided by the policy.

(f) Any cash surrender value available other than in the event of default in a premium payment due on a policy anniversary, and the amount of any paid–up nonforfeiture benefit available in the event of default in a premium payment shall be determined by methods consistent with the methods under subs. (1) to (3), (6m) and (7). The amounts of any cash surrender values and of any paid–up nonforfeiture benefits granted in connection with additional benefits the same or similar to those under sub. (7) shall conform to the principles of this subsection.

(8) (a) This section does not apply to any:

1. Reinsurance.

2. Group insurance.

3. Pure endowment contract.

4. Annuity or reversionary annuity contract.

5. Term policy of uniform amount which provides no guaranteed nonforfeiture or endowment benefits of 20 years or less expiring before age 71, for which uniform premiums are payable during the entire term of the policy.

6. Term policy of decreasing amount, which provides no guaranteed nonforfeiture or endowment benefits, on which each adjusted premium, calculated under subs. (4) to (6m) is less than the adjusted premium calculated under subs. (4) to (6m) on a term policy of uniform amount providing no guaranteed nonforfeiture or endowment benefits, issued at the same age and for the same initial amount of insurance and for a term of 20 years or less expiring before age 71, for which uniform premiums are payable during the entire term of the policy.

7. Policy providing no guaranteed nonforfeiture or endowment benefits, for which any cash surrender value or present value of any paid–up nonforfeiture benefit, at the beginning of any policy year, calculated under subs. (2) to (6m), does not exceed 2.5 percent of the amount of insurance at the beginning of the same policy year.

8. Policy delivered outside this state through an agent or other representative of the company issuing the policy.

(b) For purposes of this subsection, the age at expiry for a joint term life insurance policy is the age at expiry of the oldest life.

(9) After May 22, 1943, any company may file with the commissioner a written notice of its intention to comply with the provisions hereof after a specified date before January 1, 1948. After the filing of such notice, then upon such specified date, this section shall become fully effective with respect to policies thereafter issued by such company and all previously existing provisions of law inconsistent with this section shall become inapplicable to such policies. Except as herein provided, this section shall become effective January 1, 1948, and shall from and after said date supersede all provisions of law inconsistent or in conflict therewith.

History: 1973 c. 303; 1977 c. 153 s. 1; 1977 c. 339 s. 15; Stats. 1977 s. 632.43; 1979 c. 110 s. 60 (13); 1981 c. 307; 1983 a. 189, 538; 1995 a. 225; 2009 a. 177; 2015 a. 90.

632.435 Standard nonforfeiture law for individual deferred annuities. (1) No contract of annuity shall be delivered or issued for delivery in this state unless it contains in substance the following provisions or corresponding provisions which in the opinion of the commissioner are at least as favorable to the contract holder:

(a) Upon cessation of payment of considerations under a contract, or upon the written request of the contract owner, the company shall grant a paid–up annuity on a plan stipulated in the contract of such value as is specified in subs. (5) to (8) and (10).

(b) If a contract provides for a lump sum settlement at maturity or at any other time, upon surrender of the contract at or prior to the commencement of any annuity payments, the company shall pay in lieu of any paid–up annuity benefit a cash surrender benefit of such amount as is specified in subs. (5), (6), (8), and (10). The company may reserve the right to defer the payment of such cash surrender benefit, for a period not exceeding 6 months after demand therefor with surrender of the contract, if the company receives written approval from the commissioner upon the company's written request, which shall address the deferral's necessity and equitability to all policyholders.

(c) A statement of the mortality table, if any, and interest rates used in calculating any minimum paid–up annuity, cash surrender

or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of such benefits.

(d) A statement that any paid–up annuity, cash surrender or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which such benefits are altered by the existence of any additional amounts credited by the company to the contract, any indebtedness to the company on the contract or any prior withdrawals from or partial surrenders of the contract.

(e) Notwithstanding the requirements of this subsection, any deferred annuity contract may provide that if no considerations have been received under a contract for a period of 2 years and the portion of the paid–up annuity benefit at maturity on the plan stipulated in the contract arising from considerations paid prior to such period would be less than $20 monthly, the company may terminate such contract by payment in cash of the then present value of such portion of the paid–up annuity benefit, calculated on the basis of the mortality table, if any, and interest rate specified in the contract for determining the paid–up annuity benefit, and by such payment shall be relieved of any further obligation under such contract.

(4) (a) In this subsection, "net considerations" means, for a given contract year, an amount equal to 87.5 percent of the gross considerations credited to the contract during that contract year.

(b) The minimum nonforfeiture amount at or prior to the commencement of any annuity payments shall be equal to an accumulation up to such time, at one or more rates of interest as indicated in pars. (c) to (e), of the net considerations paid prior to such time, decreased by the sum of all of the following:

1. Any prior withdrawals from or partial surrenders of the contract accumulated at one or more rates of interest as indicated in pars. (c) to (e).

2. An annual contract charge of $50, accumulated at one or more rates of interest as indicated in pars. (c) to (e).

3. Any premium tax paid by the company for the contract, accumulated at one or more rates of interest as indicated in pars. (c) to (e).

4. The amount of any indebtedness to the company on the contract, including interest due and accrued.

(c) The interest rate used to determine minimum nonforfeiture amounts shall be an annual rate of interest that is the lower of 3 percent and the higher of either of the following:

1. The 5–year constant maturity treasury rate reported by the federal reserve board as of a date, or average over a period, specified in the contract no longer than 15 months prior to the contract issue date or redetermination date under par. (d), less 125 basis points or, if the contract provides substantive participation in an equity indexed benefit during the period or term, the contract may increase the reduction by up to an additional 100 basis points to reflect the value of the equity index benefit, and rounded to the nearest one–twentieth of 1 percent.

2. One percent.

(d) The interest rate determined under par. (c) shall apply for an initial period and may be redetermined for additional periods. The redetermination date, basis, and period, if any, shall be stated in the contract. The basis is the date or average over a specified period that produces the value of the 5–year constant maturity treasury rate to be used at each redetermination date. The method for determining the interest rate under par. (c) shall be specified in the contract if the interest rate will be reset.

(e) The present value at the contract issue date, and at each redetermination date, of the additional reduction under par. (c) 1. for substantive participation in an equity index benefit may not exceed the market value of the benefit. The commissioner may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit. The commissioner may disallow or limit the additional reduction if the commissioner determines that the demonstration is unacceptable.

(f) The commissioner may promulgate rules for the implementation of par. (e) and to provide for further adjustments to the calculation of minimum nonforfeiture amounts for contracts that provide substantive participation in an equity index benefit and for other contracts for which the commissioner determines adjustments are justified.

(5) Any paid–up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. Such present value shall be computed using the mortality table, if any, and the interest rate or rates specified in the contract for determining the minimum paid–up annuity benefits guaranteed in the contract.

(6) For contracts which provide cash surrender benefits, such cash surrender benefits available prior to maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid–up annuity benefit which would be provided under the contract at maturity arising from considerations paid prior to the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract, such present value being calculated on the basis of an interest rate not more than one percent higher than the interest rate specified in the contract for accumulating the net considerations to determine such maturity value, decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the company to the contract. No cash surrender benefit shall be less than the minimum nonforfeiture amount at that time. The death benefit under such contracts shall be at least equal to the cash surrender benefit.

(7) For contracts which do not provide cash surrender benefits, the present value of any paid–up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid–up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid–up annuity, such present value being calculated for the period prior to the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine such maturity value, and increased by any existing additional amounts credited by the company to the contract. For contracts which do not provide any death benefits prior to the commencement of any annuity payments, such present values shall be calculated on the basis of such interest rate and the mortality table specified in the contract for determining the maturity value of the paid–up annuity benefit, but the present value of a paid–up annuity benefit shall be not less than the minimum nonforfeiture amount at that time.

(8) For the purpose of determining the benefits calculated under subs. (6) and (7), in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election shall be permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant's 70th birthday or the 10th anniversary of the contract, whichever is later.

(9) Any contract which does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the commencement of any annuity payments shall include a statement in a prominent place in the contract that such benefits are not provided.

(10) Any paid–up annuity, cash surrender or death benefits available at any time, other than on the contract anniversary under any contract with fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract

year in which cessation of payment of considerations under the contract occurs.

(11) For any contract which provides within the same contract, by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding subs. (5) to (8) and (10), additional benefits payable in the event of total and permanent disability, as reversionary annuity or deferred reversionary annuity benefits or as other policy benefits additional to life insurance, endowment and annuity benefits, and considerations for all such additional benefits, shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid–up annuity, cash surrender and death benefits that may be required by this section. The inclusion of such additional benefits shall not be required in any paid–up benefits, unless such additional benefits separately would require minimum nonforfeiture amounts, paid–up annuity, cash surrender and death benefits.

(13) This section does not apply to any reinsurance, group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer (including a partnership or sole proprietorship), an employee organization or both (other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the U.S. internal revenue code, as now or hereafter amended), premium deposit fund, variable annuity, investment annuity, immediate annuity, deferred annuity contract after annuity payments have commenced, reversionary annuity or any contract which is delivered outside this state through an agent or other representative of the company issuing the contract.

History: 1977 c. 153; 1979 c. 110 s. 60 (13); 2003 a. 261.

632.44 Required provisions in life insurance. (1) SEPARATE BENEFITS. Every life insurance policy shall specify separately each benefit promised in the policy.

(2) GRACE PERIOD. Every life insurance policy other than a group policy shall contain a provision entitling the policyholder to a grace period of not less than 31 days for the payment of any premium due except the first, during which the death benefit shall continue in force.

(3) CREDIT LIFE. (a) Individual credit life insurance policies shall be for nonrenewable, nonconvertible, term insurance. This restriction does not apply when evidence of insurability is required nor when the credit transaction is for more than 5 years.

(b) When the insured debtor has paid or has made an obligation to pay all or any part of the premium under an individual credit life insurance policy, the total charge to the debtor shall be shown in the policy issued to the insured debtor. However, the rate of charge to the debtor rather than the total charge may be shown where the indebtedness is variable from period to period and the premium is computed periodically on the outstanding balance. The policy shall contain provision for cancellation of insurance upon termination of indebtedness through prepayment and shall provide for a refund of any unearned charge to the debtor, computed on a formula filed with the commissioner.

(c) The insurer shall fully control and be responsible for the settlement or adjustment of all claims.

History: 1975 c. 375, 421.

Cross–reference: See also ss. Ins 2.05, 3.25, and 3.26, Wis. adm. code.

632.45 Contracts providing variable benefits. (1) IDENTIFICATION. Any contract issued under s. 611.25 or under any section of chs. 600 to 646 incorporating s. 611.25 by reference which provides for payment of benefits in variable amounts shall contain a statement of the essential features of the procedure to be followed by the insurer in determining the dollar amount of the variable benefits. It shall contain appropriate nonforfeiture benefits in lieu of those under s. 632.43 or 632.435 and a grace provision appropriate to such a contract in lieu of the provision required by s. 632.44. Any such individual contract and any such certificate issued under a group contract shall state that the dollar amount may decrease or increase and shall conspicuously display on its first page a statement that the benefits thereunder are on a variable basis, with a statement where in the contract the details of the variable provisions may be found.

(2) AMENDMENTS. Any contract under sub. (1) shall state whether it may be amended as to investment policy, voting rights, and conduct of the business and affairs of any segregated account. Subject to any preemptive provision of federal law, any such amendment is subject to filing under s. 631.20 and approval by a majority of the policyholders in the segregated account.

(3) MARKETING PLAN. Contracts under sub. (1), if they are not forms, may be issued only within the terms of a general marketing plan approved by the commissioner. The marketing plan shall be designed to protect the interests of the policyholders in regard to any voting rights and operation of the segregated account and amendment of the contract.

History: 1975 c. 375; 1977 c. 153 s. 6; 1977 c. 339 s. 44; 1979 c. 89, 102, 177; 1989 a. 332; 2007 a. 168.

632.46 Incontestability and misstated age. (1) INCONTESTABILITY OF INDIVIDUAL POLICIES. Except under sub. (3) or (4) or for nonpayment of premiums, no individual life insurance policy may be contested after it has been in force from the date of issue for 2 years during the lifetime of the person whose life is at risk.

(2) INCONTESTABILITY OF GROUP POLICIES. Except under sub. (3) or (4) or for nonpayment of premiums, no group life insurance policy may be contested after it has been in force for 2 years from its date of issue and no coverage of any insured thereunder may be contested on the basis of a statement made by the insured relative to his or her insurability after the coverage has been in force on the insured for 2 years during the lifetime of the insured. No such statement may be used to contest coverage unless contained in a written instrument signed by the insured person.

(3) MISSTATED AGE OR SEX. (a) Subject to par. (b), if the age or sex of the person whose life is at risk is misstated in an application for a policy of life insurance and the error is not adjusted during the person's lifetime the amount payable under the policy is what the premium paid would have purchased if the age or sex had been stated correctly.

(b) If the person whose life is at risk was, at the time the insurance was applied for, beyond the maximum age limit designated by the insurer, the insurer shall refund at least the amount of the premiums collected under the policy.

(4) DISABILITY COVERAGES AND ADDITIONAL ACCIDENT BENEFITS. Despite subs. (1) and (2), disability coverages and additional accident benefits may be contested at any time on the ground of fraudulent misrepresentation.

History: 1975 c. 373, 375, 422; 1979 c. 102.

632.47 Assignment of life insurance rights. (1) GENERAL. Except as provided in sub. (3), the owner of any rights under a life insurance policy or annuity contract may assign any of those rights, including any right to designate a beneficiary and the rights secured under s. 632.57 or any other statute. An assignment valid under general contract law vests the assigned rights in the assignee subject, so far as reasonably necessary for the protection of the insurer, to any provisions in the insurance policy or annuity contract inserted to protect the insurer against double payment or obligation.

(2) RELATIVE RIGHTS OF ASSIGNEE AND BENEFICIARY. The rights of a beneficiary under a life insurance policy or annuity contract are subordinate to those of an assignee, unless the beneficiary was effectively designated as an irrevocable beneficiary prior to the assignment.

(3) PROHIBITION ON ASSIGNMENT. Assignment may be expressly prohibited by any of the following:

(a) A group contract providing annuities as retirement benefits.

(b) An annuity contract that is subject to transferability restrictions under any federal or state tax, employee benefit or securities law.

History: 1975 c. 373, 375, 422; 1999 a. 30.

632.475 Life insurance policy loans. (1) DEFINITIONS. In this section:

(a) "Policy" includes a life insurance policy, a certificate issued by a fraternal benefit society and an annuity contract.

(b) "Policy loan" means a loan by an insurer, including a premium loan, secured by the cash surrender value of a policy issued by the insurer.

(c) "Policy year" means a year beginning on the anniversary date of a policy.

(2) INTEREST RATES. A policy providing for policy loans shall contain a provision for a maximum interest rate on the loans in accordance with one but not both of the following:

(a) A provision permitting an adjustable maximum rate established from time to time by the insurer.

(b) A provision permitting a specified rate not exceeding 12 percent per year.

(3) ADJUSTABLE MAXIMUM RATE. The rate of interest charged on a policy loan under sub. (2) (a) shall not exceed the higher of the following:

(a) The rate used to compute the cash surrender values under the policy during the applicable period plus 1 percent per year.

(b) Moody's corporate bond yield monthly average, as published by Moody's Investors Service, Inc., or its successor, for the month ending 2 months before the rate is applied. If the monthly average is no longer published, a comparable average shall be substituted by the commissioner by rule.

(4) FREQUENCY OF CHANGES. If the maximum rate of interest is determined under sub. (2) (a) the policy shall contain a provision setting forth the frequency at which the rate is to be determined for that policy.

(5) INTERVALS AND LIMITS ON CHANGES. The maximum rate of interest for a policy subject to sub. (2) (a) shall be determined at regular intervals at least once every 12 months, but not more frequently than once in any 3–month period. At the intervals specified in the policy:

(a) The rate being charged may be changed as permitted under sub. (3) but no such change shall be less than 0.5 percent per year; and

(b) The rate being charged must be reduced to or below the maximum rate as determined under sub. (3) whenever the maximum is lower than the rate being charged by 0.5 percent or more per year.

(6) NOTICE. The life insurer shall:

(a) Notify the policyholder of the initial rate of interest on the loan at the time a policy loan is made, if the loan is not a premium loan.

(b) Notify the policyholder with respect to premium loans of the initial rate of interest on the loan as soon as it is reasonably practical to do so after making the initial loan. Notice need not be given to the policyholder when a further premium loan is added, except as provided in par. (c).

(c) Send to policyholders with loans 30 days' advance notice of any increase in the interest rate.

(7) COVERAGE CONTINUATION. No policy may terminate in a policy year as the sole result of a change in the loan interest rate during that policy year. The insurer shall maintain coverage until it would have terminated if there had been no change.

(8) POLICY PROVISIONS. The pertinent provisions of subs. (2) and (4) shall be set forth in substance in the policies to which they apply.

History: 1981 c. 51; 1983 a. 215; 2001 a. 103.

632.48 Designation of beneficiary. (1) POWERS OF POLICYHOLDERS. Subject to s. 632.47 (2), no life insurance policy or annuity contract may restrict the right of a policyholder or certificate holder:

(a) *Irrevocable designation of beneficiary.* To make at any time an irrevocable designation of beneficiary effective at once or at some subsequent time; or

(b) *Change of beneficiary.* If the designation of beneficiary is not explicitly irrevocable, to change the beneficiary without the consent of the previously designated beneficiary. Subject to s. 853.17, as between the beneficiaries, any act that unequivocally indicates an intention to make the change is sufficient to effect it.

(2) PROTECTION OF INSURER. An insurer may prescribe formalities to be complied with for the change of beneficiaries, but formalities prescribed under this subsection shall be designed only for the protection of the insurer. The insurer discharges its obligation under the insurance policy or certificate of insurance if it pays a properly designated beneficiary unless it has actual notice of either an assignment or a change in beneficiary designation made under sub. (1) (b). It has actual notice if the prescribed formalities are complied with or if the change in beneficiary has been requested in the form prescribed by the insurer and delivered to an intermediary representing the insurer.

(3) NOTICE OF CHANGES. An insurer that receives a request from the department of health services under s. 49.47 (4) (cr) 2. for notification shall comply with the request and notify the department of any changes to or payments made under the annuity contract to which the request for notification relates.

History: 1975 c. 373, 375, 422; 1979 c. 93; 2007 a. 20 ss. 3666, 9121 (6) (a).

Legislative Council Note, 1979: The amendment to sub. (2) adds a situation in which the insured has acted reasonably in dealing with a representative of the insurer. As between the insurer and the insured, the burden should fall upon the insurer if the agent makes an error of this kind. The insurer, of course, may have a cause of action against its agent. [Bill 20–S]

Under the facts of the case, the decedent's oral instruction to his attorney to change a beneficiary was a sufficient "act" under sub. (1) (b) even though the new beneficiary was not designated with sufficient specificity. Empire General Life Insurance v. Silverman, 135 Wis. 2d 143, 399 N.W.2d 910 (1987).

632.50 Estoppel from medical examination. If under the rules of any insurer issuing life insurance, its medical examiner has authority to issue a certificate of health, or to declare the proposed insured acceptable for insurance, and so reports to the insurer or its agent, the insurer is estopped to set up in defense of an action on the policy issued thereon that the proposed insured was not in the condition of health required by the policy at the time of issue or delivery, or that there was a preexisting condition not noted in the certificate or report, unless the certificate or report was procured through the fraudulent misrepresentation or nondisclosure by the applicant or proposed insured.

History: 1975 c. 375.

Estoppel under this section may apply against insurers who seek a medical examiner's opinion regarding fitness for insurance without establishing any formal rules regarding the examiner's authority. Grosse v. Protective Life Insurance Co. 182 Wis. 2d 97, 513 N.W.2d 592 (1994).

632.56 Required group life insurance provisions. Every group life insurance policy shall contain the following:

(1) EVIDENCE OF INSURABILITY. A provision setting forth any conditions under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of that coverage.

(2) MISSTATEMENT OF AGE. A provision specifying that an equitable adjustment of premiums or of benefits or of both will be made if the age of an insured person has been misstated and clearly stating the method of adjustment.

(3) FACILITY OF PAYMENT. A provision that any sum becoming due by reason of the death of an insured person is payable to the beneficiary designated by the insured person, subject to policy provisions if there is no designated beneficiary, and to any right reserved by the insurer in the policy and set forth in the certificate to pay at its option a part of the sum not exceeding $1,000 to any person appearing to the insurer to be equitably entitled thereto by reason of having incurred funeral or other expenses incident to the last illness or death of the insured person. This subsection does not apply to a policy issued to a creditor to insure his or her debtors.

(4) NONFORFEITURE. If it is not term insurance, equitable nonforfeiture provisions, but they need not be the same provisions as are in individual policies.

(5) GRACE PERIOD. A provision that the policyholder is entitled to a grace period of not less than 31 days for the payment of any premium due except the first. During the grace period the death benefit coverage shall continue in force, unless the policyholder gives the insurer advance written notice of discontinuance in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a proportional premium for the time the policy was in force during the grace period.

History: 1975 c. 375, 421; 1979 c. 110 s. 60 (11).

632.57 Conversion option in group and franchise life insurance. (1) SCOPE OF APPLICATION. This section applies to all group life insurance policies other than credit life insurance policies and applies to franchise life insurance policies providing term insurance renewable only while the insured is a member of the franchise unit.

(2) CONVERSION RIGHT UPON LOSS OF ELIGIBILITY. If the insurance, or any portion of it, on a person insured under a policy covered by this section ceases because of termination of employment or of membership in the class or franchise unit eligible for coverage, the insurer shall, upon written application and payment of the first premium within 31 days after the termination, issue to the person, without evidence of insurability, an individual policy providing benefits reasonably similar in type and amount to those of the group or franchise insurance, but which need not include disability or other supplementary benefits.

(3) TERMS OF CONVERSION. (a) *Form of policy.* The individual policy shall, at the option of the applicant, be on any form then customarily issued by the insurer, except term insurance, at the age and for the amount applied for.

(b) *Amount of coverage.* The individual policy shall, at the option of the applicant, be in an amount as large as in the group or franchise life insurance which ceases, less any amount of insurance which has then matured as an endowment payable to the insured person, whether in one sum or in installments or in the form of an annuity.

(c) *Premium rates.* The premium on the individual policy shall be at the customary rate then applied generally by the insurer to policies in the form and amount of the individual policy, to the class of risk to which the person then belongs without applying individual underwriting considerations, except as to occupation or avocation, and to the person's age on the effective date of the individual policy.

(4) CONVERSION UPON TERMINATION OF GROUP OR FRANCHISE INSURANCE. If the group or franchise policy terminates or is amended so as to terminate the insurance of any class of insured persons, the insurer shall, on written application and payment of the first premium within 31 days after the termination, issue to any person whose insurance is thus terminated or amended, after having been in effect for at least 5 years, an individual policy on the same conditions as in subs. (2) and (3), less the amount of any other group or franchise insurance made available to the person within 31 days thereafter as a consequence of the termination or amendment. The group policy may provide that the maximum amount of insurance available under this subsection is an amount not less than $2,000 without a conversion charge and an additional amount not less than $3,000 by paying the insurer's usual conversion charge on the additional amount.

(5) EXTENSION OF CLAIMS UNDER GROUP OR FRANCHISE POLICY. If a person insured under the group or franchise policy dies during the conversion period under sub. (2) to (4) and before an individual policy is effective, the amount of life insurance which the person would have been entitled to have issued as an individual policy shall be payable as a claim under the group or franchise policy, whether or not the person has applied for the individual policy or paid the first premium.

History: 1975 c. 375, 421; 2001 a. 103.

632.60 Limitation on credit life insurance. Nothing in chs. 600 to 646 authorizes licensees under s. 138.09 to require or accept insurance not permitted under s. 138.09 (7) (h).

History: 1975 c. 375; 1979 c. 89.

632.62 Participating and nonparticipating policies. (1) AUTHORIZATION. (a) *Stock insurers.* A stock insurer may issue both participating and nonparticipating life insurance policies and annuity contracts, subject to this section.

(b) *Fraternals and mutual insurers.* A fraternal or mutual insurer issuing life insurance policies may issue only participating policies, except for the following situations in which it may issue nonparticipating policies:

1. Paid–up, temporary, pure endowment insurance and annuity settlements provided in exchange for lapsed, surrendered or matured policies;

2. Annuities beginning within one year of the making of the contract; and

3. Such term insurance policies as the commissioner may exempt by rule.

(2) PARTICIPATION. Every participating policy shall by its terms make its holder eligible to share annually in the part of the surplus to be distributed as provided in sub. (4) (b).

(3) ACCOUNTING. Every insurer issuing both participating and nonparticipating policies shall separately account for the 2 classes of business and no part of the surplus allocated to the participating class may be voluntarily transferred to the nonparticipating class.

(4) DIVIDEND PAYMENTS. (a) *Deferred dividends.* No life insurance policy or certificate may be issued in which the distribution of dividends, if any, is deferred for a period longer than one year.

(b) *Payment.* Every insurer doing a participating business shall annually ascertain the surplus over required reserves and other liabilities. After setting aside such amounts as may be lawful and considered necessary by the insurer's board of directors for providing for the growth of the company and for protecting the ability to meet ongoing and future claims and other obligations and needs under both normal and stressed environments, and after making provision for the payment of reasonable dividends upon capital stock as determined by the insurer's board of directors and such sums as are required by prior contracts to be held on account of deferred dividend policies, an insurer shall distribute as dividends the remaining surplus, if any, attributable to participating life insurance and annuity policies in such amounts, including zero, and in such allocations among the participating life insurance and annuity policies as its board of directors determines to be reasonably proportioned to its calculation of the life insurance and annuity policies' contribution to the distributable surplus. A dividend may be conditioned on the payment of the succeeding year's premium only on the first and second anniversaries of the policy.

History: 1975 c. 373, 375, 422; 1979 c. 102; 2015 a. 90.

Sub. (4) (b) mandates how a divisible surplus is to be determined. After the surplus is determined, then and only then must the insurer decide how to equitably apportion the surplus. An allocation to annuity policyholders before determining the surplus is contrary to the terms of the statute. Noonan v. Northwestern Mutual Life Insurance Co. 2004 WI App 154, 276 Wis. 2d 33, 687 N.W.2d 254, 03–1432.

632.63 Unclaimed life insurance and annuities. **(1)** DEFINITIONS. In this section:

(a) "Contract" means an annuity contract. "Contract" shall not include an annuity used to fund an employment–based retirement plan or program where the insurer does not perform the record–keeping services or the insurer is not committed by terms of the annuity contract to pay death benefits to the beneficiaries of specific plan participants.

(b) "Death master file" means the federal social security administration's death master file or any other database or service that is at least as comprehensive as the federal social security administration's death master file for determining that a person has reportedly died.

(c) "Death master file match" means a search of the death master file that results in a match of a person's name and social security number or the name and date of birth.

(d) "Knowledge of death" means one of the following:

1. Receipt of an original or valid copy of a certified death certificate.

2. A death master file match validated by the insurer in accordance with sub. (2) (a) 1. a.

(e) "Person" means an insured, contract owner, or retained asset account holder.

(f) "Policy" means any policy or certificate of life insurance that provides a death benefit. "Policy" does not include any of the following:

1. A policy or certificate of life insurance that provides a death benefit under an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 or under any federal employee benefit program.

2. A policy or certificate of life insurance that is used to fund a preneed funeral contract or prearrangement.

3. A policy or certificate of credit life or accidental death insurance.

4. A policy issued to a group master policyholder for which the insurer does not provide record–keeping services.

(g) "Record–keeping services" means those circumstances under which the insurer has agreed with a group policy or contract customer to be responsible for obtaining, maintaining, and administering in its own or its agents' systems information about each individual insured under an insured's group insurance contract, or a line of coverage thereunder, at least the following information:

1. Social security number or name and date of birth.

2. Beneficiary designation information.

3. Coverage eligibility.

4. Benefit amount.

5. Premium payment status.

(h) "Retained asset account" means any mechanism whereby the settlement of proceeds payable under a policy or contract is accomplished by the insurer or an entity acting on behalf of the insurer depositing the proceeds into an account with check or draft writing privileges, where those proceeds are retained by the insurer or its agent, pursuant to a supplementary contract not involving annuity benefits other than death benefits.

(2) INSURER CONDUCT. (a) An insurer shall perform a comparison of its insureds' in–force policies, contracts, and retained asset accounts against a death master file, on at least a semi–annual basis, by using the full death master file once, and thereafter using the death master file update files for future comparisons, to identify potential matches of its insureds. For those potential matches identified as a result of a death master file match, the insurer shall do all of the following:

1. Within 90 days of a death master file match:

a. Complete a good faith effort, which shall be documented by the insurer, to confirm the death of the insured or retained asset account holder against other available records and information.

b. Determine whether benefits are due in accordance with the applicable policy or contract.

2. If benefits are due in accordance with the applicable policy or contract:

a. Use good faith efforts, which shall be documented by the insurer, to locate the beneficiary or beneficiaries.

b. Provide the appropriate claims forms or instructions to the beneficiary or beneficiaries to make a claim, including the need to provide an official death certificate, if applicable under the policy or contract.

(b) With respect to group life insurance, insurers are required to confirm the possible death of an insured when the insurers maintain at least the following information of those covered under a policy or certificate:

1. Social security number or name and date of birth.

2. Beneficiary designation information.

3. Coverage eligibility.

4. Benefit amount.

5. Premium payment status.

(c) Every insurer shall implement procedures to account for all of the following:

1. Initials used in lieu of a first or middle name, use of a middle name, compound first and middle names, and interchanged first and middle names.

2. Compound last names; maiden or married names; and hyphens, blank spaces, or apostrophes in last names.

3. Transposition of the month and date portions of the date of birth.

(d) To the extent permitted by law, the insurer may disclose minimum necessary personal information about the insured or beneficiary to a person who the insurer reasonably believes may be able to assist the insurer to locate the beneficiary or a person otherwise entitled to payment of the claims proceeds.

(e) The insurer comparison of in–force policies, contracts, and retained asset accounts shall be conducted first to the extent that such records are available electronically and then using the most easily accessible insurer records for records that are not available electronically.

(f) Nothing in this section shall limit the insurer from requesting a valid death certificate as part of any claims validation process.

(3) FEES AND COSTS. An insurer or its service provider shall not charge any beneficiary or other authorized representative for any fees or costs associated with a death master file search or verification of a death master file match conducted pursuant to this section.

(4) PAYMENT OF BENEFITS. The benefits from a policy, contract, or a retained asset account, plus any applicable accrued contractual interest, shall first be payable to the designated beneficiaries or owners and, in the event said beneficiaries or owners cannot be found, shall escheat to the state as unclaimed property under ch. 177. Interest payable under s. 628.46 shall not be payable as unclaimed property under s. 177.07.

(5) UNCLAIMED PROCEEDS. An insurer shall report and remit unclaimed insurance proceeds in accordance with the requirements of ch. 177.

(6) UNFAIR MARKETING PRACTICES. Failure to meet any requirement of this section with such frequency as to constitute a general business practice is a violation of s. 628.34. Nothing in this section shall be construed to create or imply a private cause of action for a violation of this section.

(7) ORDERS. The commissioner may make an order regarding any of the following:

(a) Limiting an insurer's death master file comparisons required under sub. (2) (a) to the insurer's electronic searchable files or approving a plan and timeline for conversion of the insurer's files to electronic searchable files.

(b) Exempting an insurer from the death master file comparisons required under sub. (2) (a) or permitting an insurer to perform such comparisons less frequently than semi–annually upon a demonstration of hardship by the insurer.

(c) Phasing in compliance with this section according to a plan and timeline approved by the commissioner.

(8) RULES. The commissioner may adopt rules implementing and administering this section.

History: 2017 a. 192.

632.64 Certification of disability. For the purpose of insurance policies that they issue, insurers doing a life insurance business in this state shall afford equal weight to a certification of disability signed by a physician with respect to matters within the scope of the physician's professional license, to a certification of disability signed by a chiropractor with respect to matters within the scope of the chiropractor's professional license, and to a certification of disability signed by a podiatrist with respect to matters within the scope of the podiatrist's professional license. This section does not require an insurer to treat a certificate of disability as conclusive evidence of disability.

History: 1981 c. 55; 2009 a. 113.

632.65 Annuities exempt from regulation. (1) In this section, "qualified charitable gift annuity" means an annuity that satisfies all of the following:

(a) The annuity is established under a transaction that, for federal income tax purposes, is treated partly as a charitable contribution under section 170 of the Internal Revenue Code and partly as an investment in an annuity contract under section 72 of the Internal Revenue Code.

(b) The annuity meets the requirements of an annuity for which the obligation to pay is excluded from the definition of "acquisition indebtedness" under section 514 (c) (5) of the Internal Revenue Code.

(2) (a) Notwithstanding any provision of chs. 600 to 646 to the contrary and except as provided in this section, a qualified charitable gift annuity is not subject to regulation under chs. 600 to 646.

(b) A charitable organization may not issue a qualified charitable gift annuity unless the charitable organization has been in continuous existence for at least 3 years, or is a successor or affiliate of a charitable organization that has been in continuous existence for at least 3 years.

(c) A qualified charitable gift annuity contract must include the following disclosure statement: "A qualified charitable gift annuity is not insurance under the laws of this state and is not subject to regulation by the commissioner of insurance of this state or protected by an insurance guaranty fund or an insurance guaranty association."

(3) This section applies to qualified charitable gift annuities in existence on or after April 18, 2014. A person that issued before April 18, 2014, a qualified charitable gift annuity that is in existence on April 18, 2014, shall provide notice of the provisions of this section to the policy owner or beneficiary, whichever is appropriate, of the qualified charitable gift annuity.

History: 2013 a. 271; 2015 a. 195 s. 82.

632.66 Annuity contracts without life contingencies. The commissioner may by rule authorize insurers to issue annuity contracts which are without life contingencies. If the commissioner authorizes insurers to issue annuity contracts without life contingencies, the commissioner shall promulgate rules regulating those contracts.

History: 1987 a. 247.

Cross–reference: See also s. Ins 6.75, Wis. adm. code.

632.67 Effect of power of attorney for health care. Executing a power of attorney for health care under ch. 155 may not be used to impair in any manner the procurement of a life insurance policy or to modify the terms of an existing life insurance policy. A life insurance policy may not be impaired or invalidated in any manner by the exercise of a health care decision by a health care agent on behalf of a person whose life is insured under the policy and who has authorized the health care agent under ch. 155.

History: 1989 a. 200.

632.69 Life settlements. (1) DEFINITIONS. In this section:

(a) "Advertisement" means any written, electronic, or printed communication or any communication made by means of recorded telephone messages or transmitted on radio, television, the Internet, or similar communications media, including film strips, motion pictures, and videos, published, disseminated, circulated, or placed, directly or indirectly, before the public in this state for the purpose of creating an interest in or inducing a person to purchase or sell, assign, devise, bequeath, or transfer the death benefit or ownership of a policy or an interest in a policy pursuant to a life settlement contract.

(b) "Broker" means a person who, on behalf of an owner and for a fee, commission, or other valuable consideration, offers or attempts to negotiate life settlement contracts between an owner and one or more providers, or one or more brokers. "Broker" does not include an attorney or certified public accountant who is retained to represent the owner and whose compensation is not paid directly or indirectly by the provider or purchaser.

(c) "Business of life settlements" means an activity involved in the offering soliciting, negotiating, procuring, effectuating, purchasing, investing in, financing, monitoring, tracking, underwriting, selling, transferring, assigning, pledging, hypothicating, or in any other manner, acquiring an interest in a policy by means of a life settlement contract.

(d) "Chronically ill" means any of the following:

1. Being unable to perform at least 2 activities of daily living, including eating, toileting, transferring, bathing, dressing, or continence.

2. Requiring substantial supervision to monitor the health and safety of the individual due to his or her severe cognitive impairment.

3. Having a level of disability similar to that described in subd. 1., as defined by the U.S. department of health and human services.

(e) "Financing entity" means a person whose principal activity related to a life settlement is providing funds to effect the life settlement contract or purchase of one or more policies and who has an agreement in writing with one or more providers to finance the acquisition of life settlement contracts, including an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy from a life settlement provider, credit enhancer, or any entity that has a direct ownership in a policy that is the subject of a life settlement contract. "Financing entity" does not include an investor that is not an accredited investor, as defined in 17 CFR 230.501 (a), or a purchaser.

(f) "Financing transaction" means a transaction in which a licensed provider obtains financing from a financing entity including any secured or unsecured financing, any securitization transaction, or any securities offering which is either registered or exempt from registration under federal and state securities law.

(g) "Fraudulent life settlement act" includes all of the following:

1. Acts or omissions that are committed by any person, or that a person permits its employees or its agents to engage in, for the purpose of pecuniary gain, including any of the following:

a. Presenting, causing to be presented, or preparing with the knowledge or belief that it will be presented to or by a provider, broker, purchaser, financing entity, insurer, insurance producer, or any other person, false material information, or concealing material information, as part of, in support of, or concerning a fact material to an application for the issuance of a life settlement contract or a policy; the underwriting of a life settlement contract or a policy; a claim for payment or benefit under a life settlement contract or a policy; premiums paid on an insurance policy; pay-

ments and changes in ownership or beneficiary made in accordance with the terms of a life settlement contract or a policy; the reinstatement or conversion of a policy; the solicitation, offer, effectuation, or sale of a life settlement contract or a policy; the issuance of written evidence of a life settlement contract or a policy; or a financing transaction.

b. Employing any plan, device, scheme, or artifice to defraud in the business of life settlements.

c. Failing to disclose to an insurer, if the request for such disclosure has been made by the insurer, that the prospective owner has undergone a life expectancy evaluation by any person or entity other than the insurer or its authorized representatives in connection with the issuance of the policy.

2. Any of the following acts that any person does, or permits its employees or agents to do, in the furtherance of a fraud or to prevent the detection of a fraud:

a. Removing, concealing, altering, destroying, or sequestering from the commissioner the assets or records of a licensee or other person engaged in the business of life settlements.

b. Misrepresenting or concealing the financial condition of a licensee, financing entity, insurer, or other person.

c. Transacting the business of life settlements in violation of laws requiring a license, certificate of authority, or other legal authority for the transaction of the business of life settlements.

d. Filing with the commissioner or the chief insurance regulatory official of another jurisdiction a document containing false information or otherwise concealing information about a material fact from the commissioner or official.

3. Embezzlement, theft, misappropriation, or conversion of monies, funds, premiums, credits, or other property of a life settlement provider, insurer, insured, owner, or any other person engaged in the business of life settlements or insurance.

4. Recklessly entering into, negotiating, brokering, or otherwise dealing in a life settlement contract, the subject of which is a life insurance policy that was obtained by presenting false information concerning any fact material to the policy or by concealing for the purpose of misleading another information concerning any fact material to the policy, where the person or persons intended to defraud the policy's issuer, the provider, or the owner.

5. Attempting to commit; assisting, aiding, or abetting in the commission of; or conspiring to commit the acts or omissions specified in this paragraph.

6. Misrepresenting the state of residence of an owner to be a state that does not have a law substantially similar to this section for the purpose of evading or avoiding the provisions of this section.

7. STOLI.

(h) "Licensee" means a provider or broker that holds a license under sub. (2).

(i) "Life expectancy" means the arithmetic mean, considering medical records and appropriate experiential data, of the number of months an insured under the policy to be settled can be expected to live.

(j) 1. "Life settlement" means an agreement regarding the terms under which compensation or any thing of value will be paid, which compensation or thing of value is less than the expected death benefit of the policy but greater than the cash surrender value or accelerated death benefit available under the policy at the time of the application for the life settlement, in return for the owner's present or future assignment, transfer, sale, devise, or bequest of the death benefit or any interest in a policy. "Life settlement" includes all of the following:

a. The transfer for compensation or value of ownership or beneficial interest in a trust or other entity that owns a policy that insures the life of a person residing in this state, if the trust or other entity was formed or availed of for the principal purpose of acquiring one or more policies or certificates of insurance.

b. A written agreement for a loan or other lending transaction, secured primarily by an individual or group policy.

c. A premium finance loan made for a policy on, before, or after the date of issuance of the policy but only if the loan proceeds are not used solely to pay premiums for the policy and any costs or expenses incurred by the lender or the borrower in connection with the financing, or if the owner receives on the date of the premium finance loan a guarantee of the future life settlement value of the policy, or if the owner agrees on the date of the premium finance loan to sell the policy or any interest in its death benefit on any date following the issuance of the policy.

2. "Life settlement" does not include any of the following:

a. A policy loan by a life insurance company pursuant to the terms of the policy or accelerated death provisions contained in the policy, whether issued with the original policy or as a rider.

b. Except as provided in subd. 1. c., a premium finance loan or any loan made by a bank or other licensed financial institution, provided that neither default on such loan nor the transfer of the policy in connection with such default is pursuant to an agreement or understanding with any other person for the purpose of evading regulation under this section.

c. A collateral assignment of a policy by an owner.

d. A loan made by a lender that does not violate s. 138.12, if the loan is not described in subd. 1. c. and is not otherwise a life settlement contract.

e. An agreement where all the parties are closely related to the insured by blood or law, or have a lawful substantial economic interest in the continued life, health, and bodily safety of the person insured, or are trusts or other entities established primarily for the benefit of such parties.

f. Any designation, consent, or agreement by an insured who is an employee of an employer in connection with the purchase by the employer, or trust established by the employer, of life insurance on the life of the employee.

g. A bona fide business succession planning arrangement between one or more shareholders in a corporation or between a corporation and one or more of its shareholders or one or more trusts established by or for the benefit of its shareholders; between one or more partners in a partnership or between a partnership and one or more of its partners or one or more trusts established by or for the benefit of its partners; or between one or more members in a limited liability company or between a limited liability company and one or more of its members or one or more trusts established by or for the benefit of its members.

h. An agreement, contract, or transaction that the commissioner excludes by rule under sub. (20) (a) after determining that the agreement, contract, or transaction is not intended to be regulated by this section.

(k) "Life settlement contract" means a written document providing for and establishing the terms of a life settlement.

(L) "Owner" means the owner of a policy or a certificate holder under a group policy who resides in this state, unless the context requires otherwise, and enters or seeks to enter into a life settlement contract. "Owner" does not include any of the following:

1. A licensee under this section, including a producer acting as a broker under this section.

2. A qualified institutional buyer, as defined in 17 CFR 230.144A (a) (1).

3. A financing entity.

4. A special purpose entity.

5. A related provider trust.

(m) "Policy" means an individual or group policy, certificate, contract, or arrangement of life insurance owned by a resident of this state, regardless of whether delivered or issued for delivery in this state.

(n) "Premium finance loan" means a loan made primarily for the purpose of making premium payments on a policy that is secured by an interest in the policy.

(o) "Producer" means any person licensed in this state as a resident or nonresident insurance intermediary or agent who has received qualification or authority for life insurance coverage or a life line of coverage pursuant to s. 628.04.

(p) "Provider" means a person, other than an owner, that enters into or effectuates a life settlement contract with an owner. "Provider" does not include:

1. A bank, savings bank, savings and loan association, credit union, or other licensed lending institution that takes an assignment of a policy solely as collateral for a loan.

2. A premium finance company making premium finance loans and exempted by the commissioner from the licensing requirement under the premium finance law under s. 138.12 that takes an assignment of a policy solely as collateral for a loan.

3. The issuer of a policy.

4. An authorized or eligible insurer that provides stop loss coverage or financial guaranty insurance to a provider, purchaser, financing entity, special purpose entity, or related provider trust.

5. Any natural person who enters into or effectuates no more than one agreement in a calendar year for the transfer of a policy for any value less than the expected death benefit.

6. A special purpose entity.

7. A related provider trust.

8. A purchaser.

9. A person that the commissioner excludes by rule under sub. (20) (a) after determining that the definition is not intended to cover the person.

(q) "Purchase agreement" means a contract or agreement entered into by a purchaser, to which the owner is not a party, to purchase a settled policy or an interest in a settled policy for the purpose of deriving an economic benefit.

(r) "Purchaser" means a person who provides a sum of money as consideration for a policy or an interest in the death benefits of a policy, or a person who owns or acquires or is entitled to a beneficial interest in a trust that owns a life settlement contract or is the beneficiary of a policy that has been or will be the subject of a life settlement contract, for the purpose of deriving an economic benefit. "Purchaser" does not include any of the following:

1. A licensee.

2. An accredited investor, as defined in 17 CFR 230.501 (a), or qualified institutional buyer, as defined in 17 CFR 230.114A (a) (1).

3. A financing entity.

4. A special purpose entity.

5. A related provider trust.

(s) "Recklessly" means in conscious and clearly unjustifiable disregard of a substantial likelihood of the existence of the relevant facts or risks, the disregard involving a gross deviation from acceptable standards of conduct.

(t) "Related provider trust" means a trust that is established by a licensed provider or a financing entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a financing transaction and that has a written agreement with the licensed provider under which the licensed provider is responsible for ensuring compliance with all statutory and regulatory requirements and under which the trust agrees to make all records and files relating to life settlement transactions available to the commissioner as if those records were maintained directly by the licensed provider.

(u) "Settled" means, with respect to a policy, acquired by a provider under a life settlement contract.

(v) "Special purpose entity" means a corporation, partnership, trust, limited liability company, or other similar entity formed solely to provide either direct or indirect access to institutional capital markets either for a financing entity or provider or in connection with a transaction in which the securities in the special purpose entity are either acquired by the owner or by a qualified institutional buyer, as defined in 17 CFR 230.114A (a) (1) or pay a fixed rate of return commensurate with established asset–backed institutional capital markets.

(w) "Stranger–originated life insurance" or "STOLI" means an act, practice, plan, or arrangement, individually or in concert with others, to initiate a life insurance policy for the benefit of a 3rd–party investor who, at the time of policy origination, has no insurable interest in the insured. STOLI includes cases in which life insurance is purchased with resources or guarantees from or through a person or entity who, at the time of policy inception, could not lawfully initiate the policy by the person or entity, and in which, at the time of inception, there is an arrangement or agreement, whether verbal or written, to directly or indirectly transfer the ownership of the policy or the policy benefits to a 3rd party. Trusts that are created to give the appearance of insurable interest, and are used to initiate policies for investors, violate insurable interest laws under s. 631.07 and the common law prohibition against wagering on life. STOLI does not include a loan, agreement, assignment, arrangement, or transaction set forth in sub. (1) (j) 2.

(x) "Terminally ill" means having an illness or sickness that can reasonably be expected to result in death in 24 months or less.

(2) LICENSING REQUIREMENTS. (a) 1. No person may act as a provider or broker for an owner, without holding a license from the commissioner.

2. A licensed attorney or a certified public accountant who is retained to represent the owner and whose compensation is not paid directly or indirectly by the provider or purchaser may negotiate life settlement contracts on behalf of the owner without having to obtain a license as a broker.

(b) An applicant shall make an application for a license to the commissioner on a form prescribed by the commissioner. For a broker's license, the applicant shall submit the fee specified in s. 601.31 (1) (mr), subject to s. 601.31 (2m). For a provider's license, the applicant shall submit the fee specified in s. 601.31 (1) (mm), subject to s. 601.31 (2m).

(c) The commissioner may not issue a license under this subsection unless the applicant provides his or her social security number or its federal employer identification number or, if the applicant does not have a social security number, a statement made or subscribed under oath or affirmation that the applicant does not have a social security number. An applicant who is providing a statement that he or she does not have a social security number, shall provide that statement along with the application for a license on a form prescribed by the department of children and families. A licensee shall provide to the commissioner the licensee's social security number, statement the licensee does not have the social security number, or federal employment identification number of the licensee at the time that the annual license renewal fee is paid, if not previously provided. The commissioner shall disclose a social security number obtained from an applicant or licensee to the department of children and families in the administration of s. 49.22, as provided in a memorandum of understanding entered into under s. 49.857. The commissioner may disclose the social security number or federal employment identification number of an applicant or licensee to the department of revenue for the purpose of requesting certifications under s. 73.0301 and to the department of workforce development for the purpose of requesting certifications under s. 108.227.

(d) 1. The commissioner shall refuse to issue or renew a license under this subsection if the person is delinquent in court–ordered payments of child or family support, maintenance, birth expenses, medical expenses, or other expenses related to the support of a child or former spouse, or if the person fails to comply, after appropriate notice, with a subpoena or warrant issued by the department of children and families or a county child support agency under s. 59.53 (5) and related to paternity or child support

proceedings, as provided in a memorandum of understanding entered into under s. 49.857.

2. The commissioner shall refuse to issue or renew a license under this subsection if the department of revenue certifies under s. 73.0301 that the applicant for the license or renewal of the license is liable for delinquent taxes or if the department of workforce development certifies under s. 108.227 that the applicant for the license or renewal of the license is liable for delinquent unemployment insurance contributions.

(e) The applicant shall provide information that the commissioner may require on forms prepared by the commissioner. The commissioner may require the applicant, at any time, to fully disclose the identity of its partners, officers, employees, and stockholders, except stockholders owning fewer than 10 percent of the shares of an applicant whose shares are publicly traded. The commissioner may refuse to issue a license if not satisfied that any officer, employee, stockholder, or partner who may materially influence the applicant's conduct meets the standards of this section.

(f) A license issued to a partnership, corporation, or other entity authorizes all members, officers, and designated employees to act as a licensee under the license, if those persons are named in the application or any supplements to the application.

(g) Upon the filing of an application and the payment of the license fee, the commissioner shall make an investigation of each applicant and shall issue a license if the commissioner finds that the applicant satisfies all of the following:

1. If applying for a provider license, has provided a detailed plan of operation.

2. Is competent and trustworthy and intends to transact its business in good faith.

3. Has a good business reputation and has either the experience, training, or education so as to be qualified in the business for which the license is applicable.

4. a. If applying for a provider license, has demonstrated evidence of financial responsibility in a format prescribed by the commissioner through either a surety bond executed and issued by an insurer authorized to issue surety bonds in this state or a deposit of cash, certificates of deposit, or securities or any combination of those in the amount of $250,000. Any surety bond issued under this subd. 4. a. shall be in the favor of this state and shall specifically authorize recovery by the commissioner on behalf of any person in this state who sustains damages as the result of erroneous acts, failure to act, conviction of fraud, or conviction of unfair practices by the provider. The commissioner shall accept as evidence of financial responsibility proof that financial instruments in accordance with the requirements in this subd. 4. a. have been filed in one state where the applicant is licensed as a provider.

b. If applying for a broker license, has provided proof of the acquisition of a policy of professional liability insurance in an amount that is satisfactory to the commissioner.

5. If the applicant is a legal entity, is formed or organized under the laws of this state or is a foreign legal entity authorized to transact business in this state, or provides a certificate of good standing from the state of its domicile.

6. Has provided to the commissioner an antifraud plan that meets the requirements of sub. (15) (i).

7. Has completed the initial training course under sub. (3) (e).

(h) The commissioner may request evidence of financial responsibility under par. (g) 4. from an applicant at any time the commissioner deems necessary.

(i) The commissioner shall not issue any license to any nonresident applicant, unless a written designation of an agent for service of process is filed and maintained with the commissioner or unless the applicant has filed with the commissioner the applicant's irrevocable consent that any action against the applicant may be commenced against the applicant by service of process on the commissioner in accordance with the procedures set forth in ss. 601.72 and 601.73.

(j) Licenses may be renewed annually on July 1 upon payment of the fee specified in s. 601.31 (1) (ms) by a broker, or the fee specified in s. 601.31 (1) (mp) by a provider. Failure to pay the fee by the renewal date shall result in the automatic revocation of the license.

(k) Each licensee shall file with the commissioner on or before the first day of March of each year an annual statement containing the information required under sub. (6) (a) and any information the commissioner requires by rule.

(L) A provider may not use any person to perform the functions of a broker unless the person holds a current, valid license as a broker.

(m) A broker may not use any person to perform the functions of a provider unless the person holds a current, valid license as a provider.

(n) A provider or broker shall provide to the commissioner new or revised information about officers, partners, directors, members, designated employees, or stockholders, except stockholders owning fewer than 10 percent of the shares of a provider or broker whose shares are publicly traded, within 30 days of the change.

(o) The insurer that issued the policy that is the subject of a life settlement contract may not be held responsible for any act or omission of a broker or provider arising out of or in connection with the life settlement, unless the insurer receives compensation for the placement of a life settlement contract from the broker or provider or from a purchaser in connection with the life settlement contract.

(3) TRAINING. (a) An individual applicant for a license under sub. (2) or a licensee who engages in the business of life settlements in this state shall receive training to ensure all of the following:

1. The individual understands the relation of life settlement transactions to the integrity of a comprehensive financial plan of an owner.

2. The individual has adequate knowledge to competently discuss the material aspects of life settlements with an owner.

3. The individual complies with the laws of this state relating to life settlements.

(b) Training required under this subsection must be approved by the commissioner and provided by an education provider that is approved by the commissioner. The commissioner may approve the training required under this subsection for continuing education under s. 628.04 (3). Training required under this subsection shall not increase the credit hours of continuing education required by statute or rule. Certification and reporting of completion of the required training shall comply with the requirements of s. Ins 28.07, Wis. Adm. Code. Any person failing to meet the requirements of this subsection shall be subject to the penalties imposed by the commissioner.

(c) The satisfaction of the training requirements of another state that are substantially similar to the requirements set forth in this subsection, and are approved by the commissioner, satisfy the requirements of this subsection.

(d) Training provided under this subsection shall include all of the following topics, at a minimum:

1. Legal structuring of life settlements.

2. Legal relationships among the parties to a life settlement.

3. Required disclosures and privacy requirements.

4. Ethical considerations in selling, soliciting, and negotiating life settlements.

5. Contract requirements.

6. Advertising.

7. Remedies.

8. Licensing requirements.

9. Additional matters as determined by the commissioner.

(e) An individual applicant for a license under sub. (2) shall complete an initial training course of not less than 8 hours. An electronic confirmation of completion of initial training shall accompany the application for initial licensure. A licensee shall complete training of not less than 4 hours every 24 months after the initial training course. A person who holds a license under s. 632.68, 2007 stats., on November 1, 2010, shall complete initial training within 6 months after November 1, 2010.

(4) LICENSE SUSPENSION, REVOCATION, OR REFUSAL TO RENEW. (a) The commissioner may suspend, revoke, or refuse to renew the license of any licensee if, after a hearing, the commissioner finds any of the following:

1. Any material misrepresentation in the application for the license.

2. That the licensee or any officer, partner, member, or director of the licensee is guilty of fraudulent or dishonest practices, is subject to a final administrative action, or is otherwise shown to be untrustworthy or incompetent to act as a licensee.

3. If the licensee is a provider, that the licensee demonstrates a pattern of unreasonably withholding payments to owners.

4. That the licensee no longer meets the requirements for licensure.

5. That the licensee or any officer, partner, member, or director of the licensee has been convicted of a felony or of any misdemeanor of which criminal fraud is an element or has pleaded other than not guilty with respect to any felony or any misdemeanor of which criminal fraud or moral turpitude is an element, regardless whether a judgment of conviction has been entered by the court.

6. If the licensee is a provider, that the licensee has entered into any life settlement contract the form of which has not been approved by the commissioner under this section.

7. If the licensee is a provider, that the licensee has failed to honor obligations set out in a life settlement contract.

8. If the licensee is a provider, that the licensee has assigned, transferred, or pledged a settled policy to a person other than a provider licensed in this state, a purchaser, an accredited investor as defined in 17 CFR 230.501 (a) or a qualified institutional buyer as defined in 17 CFR 230.144A (a) (1), a financing entity, a special purpose entity, or a related provider trust.

9. That the licensee or any officer, partner, member, or key management personnel has violated any of the provisions of this section.

(b) Nothing in this subsection limits the authority of the commissioner to summarily suspend a license under s. 227.51 (3).

(c) The commissioner shall suspend a license if the licensee is delinquent in court–ordered payments of child or family support, maintenance, birth expenses, medical expenses, or other expenses related to the support of a child or former spouse or if the licensee fails to comply, after appropriate notice, with a subpoena or warrant issued by the department of children and families or a county child support agency under s. 59.53 (5) that is related to paternity or child support proceedings, as provided in a memorandum of understanding entered into under s. 49.857.

(d) The commissioner shall revoke the license of a licensee if the department of revenue certifies under s. 73.0301 that the licensee is liable for delinquent taxes or if the department of workforce development certifies under s. 108.227 that the licensee is liable for delinquent unemployment insurance contributions.

(5) CONTRACT REQUIREMENTS. (a) No person may use a life settlement contract form or provide to an owner a disclosure statement form in this state unless first filed with and approved by the commissioner. The form is approved if the commissioner does not disapprove of the form within 30 days after filing or within a 30–day extension of that period ordered by the commissioner before the expiration of the first 30 days. To disapprove a form, the commissioner shall state in writing the reasons for disapproval sufficiently explicitly that the licensee is provided reasonable guidance in reformulating its forms. The commissioner shall disapprove a life settlement contract form or disclosure statement form if the commissioner determines the form or provisions contained in the form fail to meet the requirements of this section, are unreasonable, are contrary to the interests of the public, or are otherwise misleading or unfair to the owner.

(b) No insurer may, as a condition of responding to a request for verification of coverage or in connection with the transfer of a policy under a life settlement contract, require that the owner, insured, provider, or broker sign any form, disclosure, consent, waiver, or acknowledgment that has not been expressly approved by the commissioner for use in connection with life settlement contracts in this state.

(6) REPORTING REQUIREMENTS AND PRIVACY. (a) 1. In addition to any other requirements, the annual statement that is filed with the commissioner shall specify the total number, aggregate face amount, and life settlement proceeds of policies settled during the immediately preceding calendar year, together with a breakdown of the information by policy issue year. The annual statement shall also include the names of the insurance companies whose policies have been settled and the brokers that were involved in settling the policies. Each provider shall provide in the annual statement any information about any policy settled within 5 years of policy issuance that the commissioner may prescribe by rule.

2. Information provided in the annual statement shall be limited to those transactions in which the owner is a resident of this state and shall not include individual transaction data regarding the business of life settlements or information that there is a reasonable basis to believe could be used to identify the owner or the insured.

3. Every provider that willfully fails to file an annual statement as required in this section, or willfully fails to reply within 30 days to a written inquiry by the commissioner regarding the annual statement, shall be subject to a forfeiture under s. 601.64 (3) (c) and to license suspension, revocation, or nonrenewal.

(b) A provider, broker, insurance company, producer, information bureau, rating agency or company, or any other person with actual knowledge of an insured's identity, shall not disclose the identity of an insured or information that there is a reasonable basis to believe could be used to identify the insured or the insured's financial or medical information to any other person unless one of the following applies:

1. The disclosure is necessary to effect a life settlement contract between the owner and a provider, and the owner and insured have provided prior written consent to the disclosure.

2. The disclosure is necessary to effectuate a sale of life settlement contracts, or interests in life settlement contracts, as investments, if the sale is conducted in accordance with applicable state and federal securities law and if the owner and the insured have both provided prior written consent to the disclosure.

3. The disclosure is provided in response to an investigation or examination by the commissioner or any other governmental officer or agency or pursuant to the requirements of sub. (15).

4. The disclosure is a term or condition of the transfer of a policy by one provider to another provider. In such cases, the receiving provider shall be required to comply with the confidentiality requirements of this subsection.

5. The disclosure is necessary to allow the provider or broker or their authorized representatives to make contacts for the purpose of determining health status. For the purposes of this subdivision, "authorized representative" does not include any person who has or may have any financial interest in the life settlement contract other than a provider, broker, financing entity, related provider trust, or special purpose entity. A provider or broker shall require its authorized representative to agree in writing to adhere to the privacy provisions of this subsection.

6. The disclosure is required to purchase stop loss coverage.

(c) Nonpublic personal information solicited or obtained in connection with a proposed or actual life settlement contract shall

be subject to all applicable laws of this state relating to confidentiality of nonpublic personal information.

(7) EXAMINATIONS AND ALTERNATIVES. (a) The commissioner may, whenever the commissioner determines it is necessary in order to be informed about any matter related to the enforcement of this section, examine the business and affairs of any licensee or applicant for a license, under the provisions of ss. 601.43 to 601.45.

(b) The commissioner shall consider names and individual identification data for all owners, purchasers, and insureds private and confidential information and shall not disclose names or identification data unless the disclosure is to another regulator or is required by law.

(c) 1. A person required to be licensed by this section shall for 5 years retain, and make available to the commissioner for inspection at all reasonable times in accordance with s. 601.42, copies of all of the following:

a. Proposed, offered, or executed life settlement contracts, purchase agreements, underwriting documents, policy forms, and applications from the date of the proposal, offer, or execution of a life settlement contract or purchase agreement, whichever is later.

b. All checks, drafts, or other evidence and documentation related to the payment, transfer, deposit, or release of funds from the date of the financing transaction, life settlement, or purchase agreement.

c. All other records and documents related to the requirements of this section.

2. Records required to be retained under subd. 1. must be legible and complete and may be retained in paper, photograph, microprocess, magnetic, mechanical or electronic media, or by any process that accurately reproduces or forms a durable medium for reproduction of a record.

(8) DISCLOSURES TO OWNER; DISCLOSURE TO INSURED. (a) 1. With each application for a life settlement, a provider or broker shall disclose to the owner, in a separate document that is signed by the owner and the provider or broker, at least all of the following information no later than the time the application for the life settlement is signed by all parties:

a. That there are possible alternatives to life settlement contracts, including any accelerated death benefits or policy loans offered under the owner's policy.

b. That the broker represents exclusively the owner, and not the insurer or the provider, and owes a fiduciary duty to the owner, including the duty to act according to the owner's instructions and in the best interest of the owner.

c. That some or all of the proceeds of the life settlement may be taxable under federal income tax and state franchise and income tax laws, and the owner should seek assistance from a professional tax advisor.

d. That proceeds from a life settlement may be subject to the claims of creditors.

e. That receipt of proceeds from a life settlement may adversely affect the owner's eligibility for Medical Assistance or other government benefits or entitlements, and the owner should seek advice from the appropriate government agencies.

f. That the owner has a right to rescind a life settlement contract before the earlier of 30 calendar days after the date upon which the life settlement contract is executed by all parties or 15 calendar days after the life settlement proceeds have been paid to the owner, as provided in sub. (11) (d). Rescission, if exercised by the owner, is effective only if both notice of the rescission is given and the owner repays all proceeds and any premiums, loans, and loan interest paid on account of the life settlement within the rescission period. If the insured dies during the rescission period, the life settlement contract is rescinded, subject to repayment by the owner or the owner's estate to the provider or purchaser of all life settlement proceeds, and any premiums, loans, and loan interest that have been paid by the provider or purchaser, which shall be repaid within 60 calendar days of the death of the insured.

g. That funds will be sent to the owner within 3 business days after the provider has received the insurer's or group administrator's written acknowledgement that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated.

h. That entering into a life settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy, to be forfeited by the owner, and the owner should seek assistance from a professional financial advisor.

i. The language: "All medical, financial, or personal information solicited or obtained by a provider or broker about an insured, including the insured's identity or the identity of family members, a spouse, or a significant other, may be disclosed as necessary to effect the life settlement between the owner and provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every 2 years."

j. That, following execution of a life settlement contract, the insured may be contacted for the purpose of determining the insured's health status and to confirm the insured's residential or business street address and telephone number, or as otherwise allowed in this section. This contact shall be limited to once every 3 months if the insured has a life expectancy of more than one year and no more than once per month if the insured has a life expectancy of one year or less. All such contacts with the insured shall be made only by a provider licensed in the state in which the owner resided at the time of the life settlement, or by an authorized representative of the provider.

2. At the time the disclosures in subd. 1. are provided, the broker or provider shall provide to the owner a brochure describing the process of life settlements that is approved by the commissioner.

(b) A provider shall disclose to the owner, either conspicuously displayed in the life settlement contract or in a separate document signed by the owner, at least all of the following information no later than the date the life settlement contract is signed by all parties:

1. The affiliation, if any, between the provider and the issuer of the policy to be settled.

2. The name, business address, and telephone number of the provider.

3. Any affiliation or contractual arrangements between the provider and the purchaser.

4. If a policy to be settled has been issued as a joint policy or involves family riders or any coverage of a life other than that of the insured under the policy to be settled, the possible loss of coverage on the other lives under the policy, together with a statement advising the owner to consult with the insurer issuing the policy for advice concerning the proposed life settlement.

5. The dollar amount of the current death benefit that will be payable to the provider under the policy. If known, the provider shall also disclose the availability of any additional guaranteed insurance benefits, the dollar amount of any accidental death and dismemberment benefits under the policy, and the extent to which the owner's interest in those benefits will be transferred as a result of the life settlement contract.

6. That the funds will be escrowed with an independent 3rd party during the transfer process; the name, business address, and telephone number of the independent 3rd party escrow agent; and that the owner may inspect or receive copies of the relevant escrow or trust agreements or documents.

(c) A broker shall disclose to the owner, either conspicuously displayed in the life settlement contract or in a separate document

signed by the owner, at least all of the following information no later than the date the life settlement contract is signed by all parties:

1. The name, business address, and telephone number of the broker.

2. A full, complete, and accurate description of all offers, counteroffers, acceptances, and rejections related to the proposed life settlement contract.

3. A written statement of any affiliation or contractual arrangement between the broker and any person making an offer in connection with the proposed life settlement contract.

4. The amount of the broker's compensation, including anything of value paid or given to the broker for the placement of the policy.

5. If any portion of the broker's compensation is taken from a proposed life settlement, the total amount of the life settlement offer and the percentage of the life settlement comprised by the broker's compensation.

(d) If the provider transfers ownership or changes the beneficiary of the policy, the provider shall communicate in writing the change in ownership or beneficiary to the insured within 20 days after the change.

(9) DISCLOSURES TO PURCHASER. (a) 1. A provider shall disclose to a purchaser, conspicuously displayed in the purchase agreement or in a separate document signed by the purchaser and provider, at least all of the following information prior to the date the purchase agreement is signed by all parties:

a. That the purchaser will receive no returns, including dividends and interest, until the insured dies and a death claim payment is made.

b. That the actual rate of return on a life settlement contract is dependent upon an accurate projection of the insured's life expectancy and the actual date of the insured's death and that an annual guaranteed rate of return is not determinable.

c. That the settled policy should not be considered a liquid purchase since it is impossible to predict the exact timing of its maturity and the funds are not available until the death of the insured and that there is no established secondary market for resale of a settled policy by the purchaser.

d. That the purchaser may lose all benefits or may receive substantially reduced benefits if the insurer goes out of business during the contract term of the life settlement investment.

e. That the purchaser is responsible for payment of the insurance premiums or other costs related to the policy, if required by the terms of the purchase agreement, even if the insured returns to health, and that the payments may reduce the purchaser's return. If a party other than the purchaser is responsible for the payment, the name and address of the party responsible for payment shall be disclosed.

f. The amount of the premiums, if applicable.

g. The name, business address, and telephone number of the independent 3rd party providing escrow services and any relationship to the broker.

h. The amount of any trust fees or expenses to be charged the purchaser.

i. Whether the purchaser is entitled to a refund of all or part of the purchaser's investment under the purchase agreement if the policy is later determined to be null and void.

j. That group policies may contain limitations or caps in the conversion rights, that additional premiums may have to be paid if the policy is converted, the name of the party responsible for payment of any additional premiums, and that if a group policy is terminated and replaced by another group policy, there may be no right to convert the original coverage.

k. The risks associated with policy contestability, including the risk that the purchaser will have no claim or only a partial claim to death benefits should the insurer rescind the policy within the contestability period.

L. Whether the purchaser will be the owner of the policy in addition to being the beneficiary, and if the purchaser is the beneficiary only and not also the owner, the special risks associated with that status, including the risk that the beneficiary may be changed or the premium may not be paid.

m. The experience and qualifications of the person who determines the life expectancy of the insured, including in–house staff, independent physicians, and specialty firms that weigh medical and actuarial data, the information the projection is based on, and the relationship of the projection maker to the provider, if any.

2. At the time the disclosures in subd. 1. are provided, the provider shall provide to the purchaser a brochure approved by the commissioner describing the process of the purchase of a settled policy.

(b) A provider shall disclose to a purchaser, in a document signed by the purchaser and provider, at least all of the following no later than at the time of the assignment, transfer, or sale of all of or an interest in a policy:

1. All the life expectancy certifications obtained by the provider in the process of determining the price to be paid to the owner.

2. Whether the premium payments or other costs related to the policy have been escrowed and, if so, the date upon which the escrowed funds will be depleted, whether the purchaser will be responsible for payment of premiums after the depletion of escrowed funds, and the amount of the premium if the purchaser is responsible for payment.

3. Whether the premiums or other costs related to the policy have been waived and, if so, whether the purchaser will be responsible for payment of the premiums if the insurer that issued the policy terminates the waiver after purchase and, if so, the amount of the premiums.

4. Whether the type of policy offered or sold is whole life, term life, universal life, a group policy, or another type of policy, any additional benefits contained in the policy, and the current status of the policy.

5. If the policy is term insurance, the special risks associated with term insurance including the purchaser's responsibility for additional premiums if the owner continues the term policy at the end of the current term.

6. Whether the policy is contestable.

7. Whether the insurer that issued the policy has any additional rights that could negatively affect or extinguish the purchaser's rights under the purchase agreement and, if so, what those rights are and under what conditions those rights are activated.

8. The name and address of the person responsible for monitoring the insured's condition, how often the monitoring is done, how the date of death is determined, and how and when the information will be transmitted to the purchaser.

(10) DISCLOSURE TO INSURER. Before initiating a plan, transaction, or series of transactions, a broker or provider shall fully disclose to the insurer a plan, transaction, or series of transactions to which the broker or provider is a party to originate, renew, continue, or finance a policy with the insurer for the purpose of engaging in the business of life settlements at any time prior to, or during the first 5 years after, issuance of the policy.

(11) GENERAL REQUIREMENTS. (a) 1. Before entering into a life settlement contract, a provider shall obtain all of the following:

a. If the owner is the insured, a written statement from a licensed attending physician that the owner is of sound mind and under no constraint or undue influence to enter into a life settlement contract.

b. A document in which the insured consents to the release of his or her medical records to a licensed provider, licensed broker,

and the insurer that issued the policy covering the life of the insured.

2. Within 20 days after an owner executes documents necessary to transfer any rights under a policy or within 20 days after the owner enters any agreement, option, promise, or any other form of understanding, express or implied, to settle the policy, the provider shall give written notice to the insurer that issued the policy that the policy has or will become a settled policy.

3. The provider shall deliver a copy of the medical release required under subd. 1. b., a copy of the owner's application for the life settlement contract, the notice required under subd. 2., and a request for verification of coverage to the insurer that issued the policy that is the subject of the life settlement. The provider shall use a form created by the National Association of Insurance Commissioners for verification of coverage unless the commissioner develops and approves another form.

4. The insurer shall respond to a request for verification of coverage that is submitted on an approved form by a provider or broker within 30 calendar days after the date the request is received and shall indicate whether, based on the medical evidence and documents provided, the insurer intends to pursue an investigation regarding the validity of the insurance contract or possible fraud. The insurer shall accept a request for verification of coverage made on a form created by the National Association of Insurance Commissioners or any other form approved by the commissioner, and shall accept an original, facsimile, or electronic copy of the request and any accompanying signed authorization.

5. Before or at the time of execution of the life settlement contract, the provider shall obtain a witnessed document in which the owner does all of the following:

a. Consents to the life settlement contract.

b. Represents that he or she has a complete understanding of the life settlement contract.

c. Represents that he or she has a complete understanding of the benefits of the policy.

d. Acknowledges that he or she is entering into the life settlement contract freely and voluntarily.

e. If applicable, acknowledges that the insured has a terminal or chronic illness and that the terminal or chronic illness or condition was diagnosed after the policy was issued.

6. If a broker performs any of the activities required in subd. 1., 2., 3., or 5., the provider shall be considered to have performed that activity.

(b) All medical information solicited or obtained by any licensee shall be subject to the applicable provisions of state law relating to confidentiality of medical information, including s. 610.70.

(c) All life settlement contracts entered into in this state shall provide the owner with an absolute right to rescind the contract before the earlier of 30 calendar days after the date on which the life settlement contract is executed by all parties or 15 calendar days after the life settlement proceeds have been sent to the owner as provided in par. (d). Rescission by the owner may be conditioned upon the owner both giving notice and repaying to the provider, within the rescission period, all proceeds of the settlement and any premiums, loans, and loan interest paid by or on behalf of the provider in connection with or as a consequence of the life settlement. If the insured dies during the rescission period, the life settlement contract is rescinded, subject to repayment, within 60 calendar days after the death of the insured, by the owner or the owner's estate to the provider or purchaser of all life settlement proceeds and any premiums, loans, and loan interest that have been paid by the provider or purchaser. If a life settlement contract is rescinded under this paragraph, ownership of the policy shall revert to the owner or the owner's estate if the owner is deceased, irrespective of any transfer of ownership of the policy by the owner, provider, or any other person. In the event of any rescission, if the provider has paid commissions or other compensation to a broker in connection with the rescinded life settlement contract, the broker shall refund the commissions and compensation to the provider within 5 business days following receipt of written demand from the provider, which demand shall be accompanied by the applicable document initiating the rescission within the rescission period, either the owner's notice of rescission or the notice of death of the insured.

(d) The provider shall instruct the owner to send the executed documents required to effect the change in ownership, assignment, or change in beneficiary directly to the independent escrow agent. Within 3 business days after the date the independent escrow agent receives the documents, or after the date the provider receives the documents if the owner erroneously provides the documents directly to the provider, the provider shall pay or transfer the proceeds of the life settlement into an escrow or trust account that is maintained in a state or federally chartered financial institution whose deposits are insured by the Federal Deposit Insurance Corporation and managed by an independent trustee or escrow agent. Upon payment of the life settlement proceeds into the escrow account, the independent escrow agent shall deliver the original change in ownership, assignment, or change in beneficiary form to the provider or related provider trust or other designated representative of the provider. Upon the escrow agent's receipt of acknowledgement of the properly completed transfer of ownership, assignment, or designation of beneficiary from the insurer, the independent escrow agent shall pay the life settlement proceeds to the owner.

(e) Failure to tender the life settlement proceeds to the owner within the time set forth in the disclosure under sub. (8) (a) 1. g., renders the life settlement contract voidable by the owner for lack of consideration until the time the proceeds are tendered to and accepted by the owner. Funds are sent by a provider to an owner as of the date that the escrow agent either releases funds for wire transfer to the owner or places a check for delivery to the owner via the U.S. postal service or other nationally recognized delivery service.

(f) For the purpose of determining the health status of the insured after the life settlement has occurred, only the provider or broker licensed in this state or a person it authorizes may contact the insured. Contact with the insured shall be limited to once every 3 months for an insured with a life expectancy of more than one year, and to no more than once per month for an insured with a life expectancy or one year or less. The provider or broker shall explain the procedure for the contacts to the owner at the time the life settlement contract is entered into. The limitations in this paragraph do not apply to any contacts with an insured for reasons other than determining the insured's health status. Providers and brokers shall be responsible for the actions of a person they authorize to make the contact.

(12) PROHIBITED CONTRACTS; REQUIRED FORM; ACKNOWLEDGEMENT; FIDUCIARY DUTY. (a) No person may enter into a life settlement contract at any time before the application or issuance of a policy that is the subject of a life settlement contract or within a 5−year period commencing with the date of issuance of the policy unless any of the following conditions have been met:

1. The owner certifies to the provider that, within the 5−year period, the policy was issued upon the owner's exercise of conversion rights arising out of a group or individual policy, provided the total of the time covered under the conversion policy plus the time covered under the prior policy is at least 60 months. The time covered under the group policy shall be calculated without regard to any change in insurance carriers, if the coverage has been continuous and under the same group sponsorship.

2. The owner submits independent evidence to the provider that any of the following conditions have been met within the 5−year period:

a. The owner or insured is terminally or chronically ill.

b. The owner's spouse or child dies.

c. The owner divorces his or her spouse.

d. The owner retires from full–time employment.

e. The owner becomes physically or mentally disabled and a physician determines that the disability prevents the owner from maintaining full–time employment.

f. A final order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor of the owner, adjudicating the owner bankrupt or insolvent, approving a petition seeking reorganization of the owner, or appointing a receiver, trustee, or liquidator to all or a substantial part of the owner's assets.

g. The sole beneficiary of the policy is a family member of the owner and the beneficiary dies.

h. The owner is a charitable organization with an insurable interest that has received from the federal Internal Revenue Service a determination letter that is currently in effect stating that the charitable organization is described in section 501 (c) (3) of the Internal Revenue Code and is exempt from federal income taxation under section 501 (a) of the Internal Revenue Code.

i. The owner or insured disposes of ownership interests in a closely held corporation pursuant to the terms of a buyout or other similar agreement in effect at the time the policy was initially issued.

j. Other circumstances exist that are established as eligible exemptions by the commissioner by rule, including substantial adverse financial circumstances or other factors substantially affecting the owner.

3. The owner certifies to the provider that the owner is entering into a life settlement contract more than 2 years after the date of issuance of a policy and, with respect to the policy, at all times before the date that is 2 years after policy issuance all of the following conditions are met:

a. Policy premiums are funded exclusively with unencumbered assets, including an interest in the policy being financed only to the extent of its net cash surrender value, provided by, or full recourse liability incurred by, the owner or a person described in sub. (1) (j) 2. e.

b. There is no agreement or understanding with any other person to guarantee any liability or to purchase, or stand ready to purchase, the policy, including through an assumption or forgiveness of a loan.

c. Neither the insured nor the policy has been evaluated for settlement.

(b) Copies of the independent evidence described in par. (a) 2. and documents required by sub. (11) (a) shall be submitted to the insurer when the provider entering into a life settlement contract with an owner submits a request to the insurer for verification of coverage. The provider shall submit, along with the copies, a letter of attestation from the provider that the copies are true and correct copies of the documents received by the provider.

(c) If the provider submits to the insurer a copy of the owner's certification under par. (a) 1. or 3. or independent evidence under par. (a) 2. when the provider submits a request to the insurer to effect the transfer of the policy to the provider, the copy conclusively establishes that the life settlement contract satisfies the requirements of this subsection and the insurer shall timely respond to the request.

(d) No insurer may, as a condition of responding to a request for verification of coverage or effecting the transfer of a policy pursuant to a life settlement contract, require that the owner, insured, provider, or broker sign any form, disclosure, consent, or waiver that has not been expressly approved by the commissioner for use in connection with life settlement contracts in this state.

(e) Upon receipt of a properly completed request for change of ownership or beneficiary of a policy, the insurer shall respond in writing within 30 calendar days with acknowledgement confirming that the change has been effected or specifying the reasons why the requested change cannot be processed.

(f) A broker represents only the owner and owes a fiduciary duty to the owner to act according to the owner's instructions and in the best interest of the owner, notwithstanding the manner in which the broker is compensated.

(13) PROHIBITED PRACTICES AND CONFLICTS OF INTEREST. (a) No person may enter into a life settlement contract if the person knows or reasonably should have known that the policy that is the subject of the life settlement contract was obtained by means of a false, deceptive, or misleading application for the policy.

(b) No person may engage in any transaction, practice, or course of business if the person knows or reasonably should know that the intent is to avoid the notice requirements of this section.

(c) No person may engage in any fraudulent act or practice in connection with any transaction relating to any life settlement involving an owner.

(d) No person may issue, solicit, market, or otherwise promote the purchase of a policy for the primary purpose of or with a primary emphasis on settling the policy.

(e) No person may enter into a premium finance agreement with any person or agency, or any person affiliated with such person or agency, pursuant to which the person who is providing premium financing receives any proceeds, fees, or other consideration, directly or indirectly, from the policy or owner of the policy or any other person with respect to the premium finance agreement or any life settlement contract or other transaction related to the policy that is in addition to the amounts required to pay the principal, interest, and service charges related to policy premiums pursuant to the premium finance agreement or subsequent sale of the agreement. Any payments, charges, fees, or other amounts in addition to the amounts required to pay the principal, interest, and service charges related to policy premiums paid under the premium finance agreement shall be remitted to the original owner of the policy or to the owner's estate if the owner is not living at the time of the determination of the overpayment.

(f) With respect to any life settlement contract or policy, no broker may knowingly solicit an offer from, effectuate a life settlement with, or make a sale to any provider, purchaser, financing entity, or related provider trust that is controlling, controlled by, or under common control with the broker unless the relationship is disclosed to the owner.

(g) With respect to any life settlement contract or policy, no provider may knowingly enter into a life settlement contract with an owner, if, in connection with the life settlement contract, anything of value will be paid to a broker that is controlling, controlled by, or under common control with the provider or the purchaser, financing entity, or related provider trust that is involved in the life settlement contract unless the relationship is disclosed to the owner.

(h) No life settlement promotional, advertising, or marketing materials may represent that the insurance is "free" for any period of time, or include any reference that would cause an owner to reasonably believe that the insurance is free for any period of time.

(i) No producer, insurer, broker, or provider may make any statement or representation to an applicant or policyholder in connection with the sale or financing of a policy to the effect that the insurance is free or without cost to the policyholder for any period of time unless provided in the policy.

(14) ADVERTISEMENTS OF LIFE SETTLEMENT CONTRACTS AND PURCHASE AGREEMENTS. (a) This subsection applies to any advertising of life settlement contracts, purchase agreements, or related products or services intended for dissemination in this state, including Internet advertising viewed by persons located in this state.

(b) If disclosure requirements are established by federal regulation, this subsection shall be interpreted so as to minimize or eliminate conflict with federal regulation.

(c) The commissioner may require a broker or provider to submit advertising material at any time.

(d) Every licensee shall establish and maintain a system of control over the content, form, and method of dissemination of all advertisements of its life settlement contracts, products, and services. All advertisements, regardless who wrote, created, designed, or presented the advertisement, shall be the responsibility of the licensee and the person who created or presented the advertisement. The system of control shall include regular routine notification of the requirements and procedures for approval prior to use of any advertisements not furnished by the licensee, at least once a year, to producers, brokers, and others authorized by the licensee who disseminate advertisements.

(e) Advertisements shall be truthful and not misleading in fact or by implication. The form and content of an advertisement of a life settlement contract or purchase agreement, product, or service shall be sufficiently complete and clear so as to avoid deception. The advertisement may not have the capacity or tendency to mislead or deceive. The commissioner shall determine whether an advertisement has the capacity or tendency to mislead or deceive 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.

(f) Disclosures that are required under this subsection may not be minimized, rendered obscure, presented in an ambiguous fashion, or intermingled with the text of the advertisement so as to be confusing or misleading.

(g) An advertisement may not do any of the following:

1. Omit material information or use words, phrases, statements, references, or illustrations if the omission or use has the capacity, tendency, or effect of misleading or deceiving an owner, purchaser, or prospective purchaser as to the nature or extent of any benefit, covered loss, premium payable, or state or federal tax consequences. A misleading statement is not remedied by any of the following:

a. Making the life settlement contract or purchase agreement available for inspection prior to consummation of the sale.

b. Offering to refund payment if the owner is not satisfied.

c. Including in the life settlement contract or purchase agreement a "free look" period that satisfies or exceeds the requirements of law.

2. Use the name or title of a life insurance company or a policy unless the advertisement has been approved by the insurer.

3. Represent that premium payments will not be required on the policy that is the subject of a life settlement contract or purchase agreement in order to maintain the policy unless that is the fact.

4. State or imply that interest charged on an accelerated death benefit or loan is unfair, inequitable, or, in any manner, an incorrect or improper practice.

5. Use the words "free," "no cost," "without cost," "no additional cost," "at no extra cost," or similar words or phrases with respect to any benefit or services, unless true. An advertisement may specify the charge for a benefit or service or may state that a charge is included in the payment or use other appropriate language.

6. Use testimonials, appraisals, analyses, or endorsements in advertisements unless they are genuine; represent the current opinion of the author; are applicable to the life settlement contract or purchase agreement, product, or service advertised; and are reproduced with sufficient completeness to avoid misleading or deceiving prospective owners or purchasers as to the nature or scope of the testimonial, appraisal, analysis, or endorsement. Any financial interest in or benefit received from the licensee by the person making a testimonial, appraisal, or analysis, directly or indirectly, shall be prominently disclosed in the advertisement. If an endorsement refers to benefits received under a life settlement contract or purchase agreement, the licensee shall retain all pertinent information forming a basis of the endorsement for a period of 5 years following its use.

7. State or imply that a life settlement contract or purchase agreement, benefit, or service has been approved or endorsed by a group, society, association, or other organization unless that is the fact and unless any relationship between the organization and the licensee is disclosed. If the entity making the endorsement is owned, controlled, or managed by the licensee, or receives any payment or other consideration from the licensee for making an endorsement or testimonial, that fact must be disclosed in the advertisement.

8. Contain statistical information unless the information accurately reflects recent and relevant facts. An advertisement shall identify the source of all statistics used in the advertisement.

9. Disparage insurers, providers, brokers, producers, policies, services, or methods of marketing.

10. Omit the name of the actual licensee from any advertisement. No advertisement may use a trade name, group designation, name of the parent company of a licensee, name of a division of a life settlement licensee, service mark, slogan, symbol, or other device or reference if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the licensee or to create the impression that any entity other than the licensee would have any responsibility for the financial obligation under a life settlement contract or purchase agreement.

11. Use any combination of words, symbols, or physical materials that by the their content, phraseology, shape, color, or other characteristics are so similar to a combination of words, symbols, or physical materials used by a government program or agency that they tend to mislead or deceive prospective owners or purchasers into believing the advertisement is in some manner connected with a government program or agency.

12. Exaggerate the fact that a licensee under this section is licensed in the state where the advertisement appears or suggest or imply that competing licensees may not be so licensed. An advertisement may ask the audience to consult the licensee's website or contact the office of the commissioner for licensing requirements and the status of a license.

13. Create the impression, directly or indirectly, that a licensee; its business practices or methods of operation; the merits, desirability, or advisability of any life settlement contract or purchase agreement; or any life insurance company are recommended, approved, or endorsed by any government entity.

14. Emphasize the speed with which the settlement will occur, except that the advertisement may disclose the average time from the completion of the application to the date of offer and from the acceptance of the offer to receipt of the settlement funds by the owner.

15. Emphasize the dollar amounts available to an owner, except that the advertisement may disclose the average purchase price as a percent of the face value obtained by owners contracting with the licensee during the prior 6 months.

(h) The name of the licensee shall be clearly identified in all advertisements about the licensee or its life settlement contracts, purchase agreements, products, or services. If any specific life settlement contract or purchase agreement of a licensee is advertised, the contract or agreement shall be identified either by form number or other appropriate description. If an application is part of the advertisement, the name of the provider shall be shown on the application.

(15) FRAUD PREVENTION AND CONTROL; FRAUDULENT LIFE SETTLEMENT ACTS. (a) No person may commit a fraudulent life settlement act.

(b) No person may knowingly or intentionally interfere with the enforcement of this subsection or sub. (13) or investigations of suspected or actual violations of this subsection or sub. (13).

(c) No person in the business of life settlements may knowingly or intentionally permit any person convicted of a felony

involving dishonesty or breach of trust to participate in the business of life settlements.

(d) 1. Life settlement contracts, purchase agreements, and applications for life settlements, regardless of the form of transmission, shall contain the following statement or a substantially similar statement: "Any person who knowingly presents false information in an application for insurance, a life settlement, or a purchase agreement may be subject to civil and criminal penalties."

2. A person may not use the lack of the statement required under subd. 1. as a defense to any prosecution for a violation of this subsection or sub. (13).

(e) 1. Any person engaged in the business of life settlements having knowledge or a reasonable belief that a violation of this subsection or sub. (13) is being, will be, or has been committed shall provide to the commissioner the information required by, and in a manner prescribed by, the commissioner.

2. Any other person having knowledge or a reasonable belief that a violation of this subsection or sub. (13) is being, will be, or has been committed may provide to the commissioner the information required by, and in a manner prescribed by, the commissioner.

(f) 1. In the absence of actual malice, no civil liability shall be imposed on and no cause of action shall arise from a person's furnishing information concerning suspected, anticipated, or completed violations of this subsection or sub. (13) or suspected, anticipated, or completed fraudulent insurance acts, if the information is provided to or received from any of the following:

a. The commissioner or the commissioner's employees, agents, or representatives.

b. Federal, state, or local law enforcement or regulatory officials or their employees, agents, or representatives.

c. A person involved in the prevention and detection of fraud or that person's agents, employees, or representatives.

d. The National Association of Insurance Commissioners, the Financial Industry Regulatory Authority, the North American Securities Administrators Association, or their employees, agents, or representatives or other regulatory body overseeing life insurance, life settlements, securities, or investment fraud.

e. The life insurer that issued the policy covering the life of the insured.

2. This paragraph does not abrogate or modify common law or statutory privileges or immunities enjoyed by a person who supplies information concerning suspected, anticipated, or completed fraudulent acts related to life settlements or insurance.

(g) Information, documents, and evidence provided under par. (e) or obtained by the commissioner in an investigation of suspected or actual violations of this subsection or sub. (13) shall be privileged and confidential, shall not be a public record, and shall not be subject to discovery or subpoena in a civil or criminal action. The commissioner may release information, documents, and evidence provided under par. (e) or obtained in an investigation of suspected or actual violations of this subsection or sub. (13) in administrative or judicial proceedings to enforce laws administered by the commissioner, to federal, state, or local law enforcement or regulatory agencies, to an organization established for the purpose of detecting and preventing fraud related to life settlements, to the National Association of Insurance Commissioners, or, at the discretion of the commissioner, to a person in the business of life settlements that is aggrieved by a violation of this subsection or sub. (13). Release by the commissioner of information, documents, and evidence as set forth in this paragraph does not abrogate, modify, or waive the privilege established in this paragraph.

(h) This section does not do any of the following:

1. Preempt the authority or relieve the duty of law enforcement or regulatory agencies other than the commissioner to investigate, examine, and prosecute suspected violations of law.

2. Prevent or prohibit a person from disclosing voluntarily information concerning life settlement fraud to a law enforcement or regulatory agency other than the commissioner.

3. Limit the powers granted elsewhere by the laws of this state to the commissioner to investigate and examine possible violations of law and to take appropriate action.

(i) 1. Providers and brokers shall have in place antifraud initiatives reasonably calculated to detect, prosecute, and prevent violations of this subsection and sub. (13). The commissioner may modify the antifraud initiatives from time to time as necessary to ensure an effective antifraud program and to accomplish the purpose of this paragraph.

2. Antifraud initiatives shall include having fraud investigators, who may be employees of the provider or broker or who may be independent contractors, and an antifraud plan, which the provider or broker shall submit to the commissioner and which shall include all of the following:

a. A description of the procedures that the provider or broker will use for detecting and investigating possible fraud and violations of this subsection and sub. (13) and for resolving material inconsistencies between medical records and insurance applications.

b. A description of the procedures that the provider or broker will use for reporting possible violations of this subsection and sub. (13) to the commissioner.

c. A description of the plan that the provider or broker will follow for antifraud education and training of underwriters and other personnel.

d. A description or chart outlining the organizational arrangement of the antifraud personnel who are responsible for investigating and reporting possible violations of this subsection and sub. (13) and investigating unresolved material inconsistencies between medical records and insurance applications.

3. Antifraud plans submitted to the commissioner are privileged and confidential, are not a public record, and are not subject to discovery or subpoena in a civil or criminal action.

(16) CONFLICTS OF LAW. If there is more than one owner on a single policy and the owners are residents of different states, a life settlement shall be governed by the law of the state in which the owner having the largest percentage ownership resides or, if the owners hold equal ownership, the state of residence of one owner agreed upon in writing by all owners.

(17) FRATERNAL BENEFIT SOCIETIES. Nothing in this section shall prohibit a fraternal benefit society under ch. 614 from enforcing the terms of its bylaws or rules regarding permitted beneficiaries and owners.

(18) CIVIL ACTION. Any person damaged by a violation of this section may bring a civil action against the person committing the violation in a court of competent jurisdiction.

(19) PENALTIES. Any person who violates this section is subject to the penalties provided under s. 601.64, suspension or revocation of a license or certificate of authority, and an order under s. 601.41.

(20) POWERS OF COMMISSIONER. The commissioner may do any of the following:

(a) Adopt rules implementing and administering this section.

(b) Establish standards for evaluating the reasonableness of payments under life settlement contracts for persons who are terminally or chronically ill, including regulation of discount rates used to determine the amount paid in exchange for assignment, transfer, sale, devise, or bequest of a benefit under a policy insuring the life of a person who is terminally or chronically ill.

(c) Establish appropriate licensing requirements and standards for continued licensure for providers and brokers.

(d) Require a bond or other mechanism for financial accountability for providers and brokers.

(e) Adopt rules governing the relationship and responsibilities of insurers, providers, and brokers during settlement of a policy.

History: 2009 a. 344; 2011 a. 209; 2011 a. 260 s. 81; 2013 a. 36; 2017 a. 365 s. 112.

632.695 Applicability of general transfers at death provisions. Chapter 854 applies to transfers at death under life insurance policies and annuities.

History: 1997 a. 188.

632.697 Benefits subject to department's right to recover. Death benefits payable under a life insurance policy or an annuity are subject to the right of the department of health services to recover under s. 46.27 (7g), 2017 stats., or s. 49.496, 49.682, or 49.849 an amount equal to the medical assistance that is recoverable under s. 49.496 (3) (a), an amount equal to aid under s. 49.68, 49.683, 49.685, or 49.785 that is recoverable under s. 49.682 (2) (a) or (am), or an amount equal to long–term community support services under s. 46.27, 2017 stats., that is recoverable under s. 46.27 (7g) (c) 1., 2017 stats., and that was paid on behalf of the deceased policyholder or annuitant.

History: 2013 a. 20; 2015 a. 55; 2019 a. 9; s. 35.17 correction.

SUBCHAPTER VI

DISABILITY INSURANCE

632.71 Estoppel from medical examination, assignability and change of beneficiary. Sections 632.47 to 632.50 apply to disability insurance policies.

History: 1975 c. 373, 375, 422.

632.715 Reports of action against health care provider. Every insurer that has taken any action against a person who holds a license granted by the medical examining board or an affiliated credentialing board attached to the medical examining board shall notify the board or affiliated credentialing board of the action taken against the person if the action relates to unprofessional conduct or negligence in treatment by the person who holds the license.

History: 1985 a. 340; 1993 a. 107.

632.72 Medical benefits or assistance; assignment. (1g) In this section:

(a) "Department or contract provider" means the department of health services, the county providing the medical benefits or assistance or a health maintenance organization that has contracted with the department of health services to provide the medical benefits or assistance.

(b) "Medical benefits or assistance" means health care services funded by a relief block grant, as defined in s. 49.001 (5p); medical assistance, as defined under s. 49.43 (8); or maternal and child health services under s. 253.05.

(1r) The providing of medical benefits or assistance constitutes an assignment to the department or contract provider. The assignment shall be, to the extent of the medical benefits or assistance provided, for benefits to which the recipient would be entitled under any policy of health and disability insurance.

(2) An insurer may not impose on the department or contract provider, as assignee of a person who is covered under the policy of health and disability insurance and who is eligible for medical benefits or assistance, requirements that are different from those imposed on any other agent or assignee of a person who is covered under the policy of health and disability insurance.

History: 1977 c. 29; 1985 a. 29; 1987 a. 27 s. 3202; 1989 a. 31, 173; 1991 a. 178, 214; 1993 a. 481; 1995 a. 27 ss. 7042 to 7046, 9126 (19); 1995 a. 407; 2007 a. 20 s. 9121 (6) (a); 2009 a. 28.

632.725 Standardization of health care billing and insurance claim forms. (1) DEFINITION. In this section, "health care provider" has the meaning given in s. 146.81 (1) (a) to (p).

(2) RULES FOR STANDARDIZATION OF FORMS. The commissioner, in consultation with the department of health services, shall, by rule, do all of the following:

(a) Establish a standardized billing format for health care services and require that a health care provider that provides health care services in this state use, by July 1, 1993, the standardized format for all printed billing forms.

(b) Establish a standardized claim format for health care insurance benefits and require that an insurer that provides health care coverage to one or more residents of this state use, by July 1, 1993, the standardized format for all printed claim forms.

(c) Establish a standardized explanation of benefits format for health care insurance benefits and require that an insurer that provides health care coverage to one or more residents of this state use, by July 1, 1993, the standardized format for all printed forms that contain an explanation of benefits. The rule shall also require that benefits be explained in easily understood language.

(d) Establish a uniform statewide patient identification system in which each individual who receives health care services in this state is assigned an identification number. The standardized billing format established under par. (a) and the standardized claim format established under par. (b) shall provide for the designation of an individual's patient identification number.

(3) PROPOSALS FOR LEGISLATION. The commissioner shall develop proposals for legislation for the use of the patient identification system established under sub. (2) (d) and for the implementation of the proposed uses, including any proposals for safeguarding patient confidentiality.

History: 1991 a. 250; 1995 a. 27 s. 9126 (19); 2007 a. 20 s. 9121 (6) (a); 2009 a. 28.

Cross–reference: See also ss. Ins 3.65 and 3.651, Wis. adm. code.

632.726 Current procedural terminology code changes. (1) In this section, "current procedural terminology code" means a number established by the American Medical Association that a health care provider puts on a health insurance claim form to describe the services that he or she performed.

(2) If an insurer changes a current procedural terminology code that was submitted by a health care provider on a health insurance claim form, the insurer shall include on the explanation of benefits form the reason for the change to the current procedural terminology code and shall cite on the explanation of benefits form the source for the change.

History: 2007 a. 20.

632.729 Prohibiting discrimination based on COVID–19. (1) DEFINITIONS. In this section:

(a) "COVID–19" means an infection caused by the SARS–CoV–2 coronavirus.

(b) "Health benefit plan" has the meaning given in s. 632.745 (11).

(c) "Pharmacy benefit manager" has the meaning given in s. 632.865 (1) (c).

(d) "Self–insured health plan" has the meaning given in s. 632.85 (1) (c).

(2) ISSUANCE OR RENEWAL. (a) An insurer that offers an individual or group health benefit plan, a pharmacy benefit manager, or a self–insured health plan may not establish rules for the eligibility of any individual to enroll, for the continued eligibility of any individual to remain enrolled, or for the renewal of coverage under the plan based on a current or past diagnosis or suspected diagnosis of COVID–19.

(b) An insurer that offers a group health benefit plan, a pharmacy benefit manager, or a self–insured health plan may not establish rules for the eligibility of any employer or other group to enroll, for the continued eligibility of any employer or group to

remain enrolled, or for the renewal of an employer's or group's coverage under the plan based on a current or past diagnosis or suspected diagnosis of COVID–19 of any employee or other member of the group.

(3) CANCELLATION. An insurer that offers an individual or group health benefit plan, a pharmacy benefit manager, or a self–insured health plan may not use as a basis for cancellation of coverage during a contract term a current or past diagnosis of COVID–19 or suspected diagnosis of COVID–19.

(4) RATES. An insurer that offers an individual or group health benefit plan, a pharmacy benefit manager, or a self–insured health plan may not use as a basis for setting rates for coverage a current or past diagnosis of COVID–19 or suspected diagnosis of COVID–19.

(5) PREMIUM GRACE PERIOD. An insurer that offers an individual or group health benefit plan, a pharmacy benefit manager, or a self–insured health plan may not refuse to grant to an individual, employer, or other group a grace period for the payment of a premium based on an individual's, employee's, or group member's current or past diagnosis of COVID–19 or suspected diagnosis of COVID–19 if a grace period for payment of premium would generally be granted under the plan.

History: 2019 a. 185.

632.73 Right to return policy. (1) RIGHT OF RETURN. A policyholder may return an individual or franchise disability policy within 10 days after receipt. If the policyholder does so, the contract is void, and all payments made under it shall be refunded. This subsection does not apply to medicare supplement policies, medicare replacement policies or long–term care insurance policies subject to sub. (2m).

(2) NOTIFICATION. Subsection (1) shall in substance be conspicuously printed on the first page of each such policy or conspicuously attached thereto.

(2m) MEDICARE SUPPLEMENT POLICIES, MEDICARE REPLACEMENT POLICIES AND LONG–TERM CARE INSURANCE POLICIES. Medicare supplement policies, medicare replacement policies and long–term care insurance policies shall have a notice that complies with this subsection prominently printed on the first page of the policy or certificate, or attached thereto. The notice shall state that the policyholder or certificate holder shall have the right to return the policy or certificate within 30 days of its delivery to the policyholder or certificate holder and to have the premium refunded to the person who paid the premium if, after examination of the policy or certificate, the policyholder or certificate holder is not satisfied for any reason. The commissioner may by rule exempt from this subsection certain classes of medicare supplement policies, medicare replacement policies and long–term care insurance policies, if the commissioner finds the exemption is not adverse to the interests of policyholders and certificate holders.

(3) EXEMPTIONS. (a) *Specified.* This section does not apply to single premium nonrenewable policies issued for terms not greater than 6 months or covering accidents only or accidental bodily injuries only.

(b) *By rule.* The commissioner may by rule permit exemptions from subs. (1) and (2) for additional classes or parts of classes of insurance where the right to return the policy would be impracticable or is not necessary to protect the policyholder's interests.

History: 1975 c. 375, 421; 1981 c. 82; 1985 a. 29; 1985 a. 332 s. 253; 1989 a. 31.

632.74 Reinstatement of individual or franchise disability insurance policies. (1) CONDITIONS OF REINSTATEMENT. If an insurer, after termination of an individual or franchise disability insurance policy for nonpayment of premium, within one year after the termination accepts without reservation a premium payment, the policy is reinstated as of the date of the acceptance. There is no acceptance without reservation if the insurer delivers or mails a written statement of reservations within 45 days after receipt of the payment.

(2) CONSEQUENCES OF REINSTATEMENT. If a policy is reinstated under sub. (1) or if the insurer within one year after the termination issues to the policyholder a reinstatement policy, any losses resulting from accidents occurring or sickness beginning between the termination and the effective date of the reinstatement or the new policy are not covered, and no premium is payable for that period, except to the extent that the premium is applied to a reserve for future losses. The insurer may also charge a reinstatement fee in accordance with a schedule that has been filed with and expressly approved by the commissioner as not excessive and not unreasonably discriminatory. In all other respects, the reinstated or renewed contract shall be treated as an uninterrupted contract subject to any provisions which are endorsed on or attached to the contract in connection with the reinstatement and which are fully and prominently disclosed to the policyholder.

History: 1975 c. 375; 1985 a. 280; 1987 a. 247.

632.745 Coverage requirements for group and individual health benefit plans; definitions. In this section and ss. 632.746 to 632.7495:

(1) "Affiliation period" means the period which, under the terms of health insurance coverage offered by a health maintenance organization, must expire before the health insurance coverage becomes effective.

(2) "Beneficiary" has the meaning given in section 3 (8) of the federal Employee Retirement Income Security Act of 1974.

(3) "Bona fide association" means an association that satisfies all of the following:

(a) The association has been actively in existence for at least 5 years.

(b) The association has been formed and maintained in good faith for purposes other than obtaining insurance.

(c) The association does not condition membership in the association on any health status–related factor of an individual, including an employee of an employer or a dependent of an employee.

(d) The association makes health insurance coverage offered through the association available to all members, regardless of any health status–related factor of those members or individuals eligible for coverage through a member.

(e) The association does not make health insurance coverage offered through the association available other than in connection with a member of the association.

(f) The association meets any additional requirements that are imposed by a rule of the commissioner designed to prevent the use of an association for risk segmentation.

(4) (a) Except as provided in par. (b), "creditable coverage" means coverage under any of the following:

1. A group health plan.

2. Health insurance.

3. Part A or part B of title XVIII of the federal Social Security Act.

4. Title XIX of the federal Social Security Act, except for coverage consisting solely of benefits under section 1928 of that act.

5. Chapter 55 of title 10 of the United States Code.

6. A medical care program of the federal Indian health service or of an American Indian tribal organization.

7. A state health benefits risk pool.

8. A health plan offered under chapter 89 of title 5 of the United States Code.

9. A public health plan, as defined in regulations issued by the federal department of health and human services.

10. A health coverage plan under section 5 (e) of the federal Peace Corps Act, 22 USC 2504 (e).

(b) "Creditable coverage" does not include coverage consisting solely of coverage of excepted benefits, as defined in section 2791 (c) of P.L. 104–191.

(5) (a) Except as provided in par. (b), "eligible employee" means an employee who works on a permanent basis and has a normal work week of 30 or more hours. The term includes a sole proprietor, a business owner, including the owner of a farm business, a partner of a partnership and a member of a limited liability company if the sole proprietor, business owner, partner or member is included as an employee under a health benefit plan of an employer, but the term does not include an employee who works on a temporary or substitute basis.

(b) For purposes of a group health benefit plan, or a self–insured health plan, that is offered by the state under s. 40.51 (6) or by the group insurance board under s. 40.51 (7), "eligible employee" has the meaning given in s. 40.02 (25).

(6) (a) "Employer" means any of the following:

1. An individual, firm, corporation, partnership, limited liability company or association that is actively engaged in a business enterprise in this state, including a farm business.

2. A municipality, as defined in s. 16.70 (8).

2m. A long–term care district under s. 46.2895.

3. The state.

(b) For purposes of this definition, all of the following apply:

1. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.

2. "Employer" includes any predecessor of an employer.

(7) "Enrollment date" means, with respect to an individual covered under a group health plan or health insurance, the date of enrollment of the individual under the plan or insurance or, if earlier, the first day of the waiting period for such enrollment.

(8) "Federal continuation provision" means any of the following:

(a) Section 4980B of the Internal Revenue Code of 1986, except for section 4980B (f) (1) of that code insofar as it relates to pediatric vaccines.

(b) Part 6 of subtitle B of title I of the federal Employee Retirement Income Security Act of 1974, except for section 609 of that act.

(c) Title XXII of P.L. 104–191.

(9) "Group health benefit plan" means a health benefit plan that is issued by an insurer to or through an employer on behalf of a group consisting of at least 2 employees or a group including at least 2 eligible employees. The term includes individual health benefit plans covering eligible employees when 3 or more are sold to or through an employer.

(10) "Group health plan" means any of the following:

(a) An employee welfare plan, as defined in section 3 (1) of the federal Employee Retirement Income Security Act of 1974, to the extent that the employee welfare plan provides medical care, including items and services paid for as medical care, to employees or to their dependents, as defined under the terms of the employee welfare plan, directly or through insurance, reimbursement, or otherwise.

(b) Any program that would not otherwise be an employee welfare benefit plan and that is established or maintained by a partnership, to the extent that the program provides medical care, including items and services paid for as medical care, to present or former partners of the partnership or to their dependents, as defined under the terms of the program, directly or through insurance, reimbursement or otherwise.

(11) (a) Except as provided in par. (b), "health benefit plan" means any hospital or medical policy or certificate.

(b) "Health benefit plan" does not include any of the following:

1. Coverage that is only accident or disability income insurance, or any combination of the 2 types.

2. Coverage issued as a supplement to liability insurance.

3. Liability insurance, including general liability insurance and automobile liability insurance.

4. Worker's compensation or similar insurance.

5. Automobile medical payment insurance.

6. Credit–only insurance.

7. Coverage for on–site medical clinics.

8. Other similar insurance coverage, as specified in regulations issued by the federal department of health and human services, under which benefits for medical care are secondary or incidental to other insurance benefits.

9. If provided under a separate policy, certificate or contract of insurance, or if otherwise not an integral part of the policy, certificate or contract of insurance: limited–scope dental or vision benefits; benefits for long–term care, nursing home care, home health care, community–based care, or any combination of those benefits; and such other similar, limited benefits as are specified in regulations issued by the federal department of health and human services under section 2791 of P.L. 104–191.

10. Hospital indemnity or other fixed indemnity insurance or coverage only for a specified disease or illness, if all of the following apply:

a. The benefits are provided under a separate policy, certificate or contract of insurance.

b. There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor.

c. Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.

11. Benefits that are provided under a separate policy, certificate or contract of insurance and that are medicare supplemental health insurance, as defined in section 1882 (g) (1) of the federal Social Security Act, coverage supplemental to the coverage provided under chapter 55 of title 10 of the United States Code or similar supplemental coverage provided as supplemental to coverage under a group health plan.

12. Other insurance exempted by rule of the commissioner.

(12) "Health insurance" includes health benefit plans but does not include group health plans.

(13) "Health maintenance organization" has the meaning given in s. 609.01 (2).

(14) "Health status–related factor" means any of the factors listed in s. 632.748 (1) (a).

(15) "Insurer" means an insurer that is authorized to do business in this state, in one or more lines of insurance that includes health insurance, and that offers health benefit plans covering individuals in this state or eligible employees of one or more employers in this state. The term includes a health maintenance organization, a preferred provider plan, as defined in s. 609.01 (4), an insurer operating as a cooperative association organized under ss. 185.981 to 185.985 and a limited service health organization, as defined in s. 609.01 (3).

(16) "Large employer" means, with respect to a calendar year and a plan year, an employer that employed an average of at least 51 employees on business days during the preceding calendar year, or that is reasonably expected to employ an average of at least 51 employees on business days during the current calendar year if the employer was not in existence during the preceding calendar year, and that employs at least 2 employees on the first day of the plan year.

(17) "Large group market" means the health insurance market under which individuals obtain health insurance coverage on behalf of themselves and their dependents, directly or through any arrangement, under a group health benefit plan maintained by a large employer.

(18) "Late enrollee" means, with respect to coverage under a group health plan or health insurance coverage, a participant, beneficiary or individual who enrolls under the plan or coverage at any time other than during any of the following:

(a) The first period in which the individual is eligible to enroll under the plan or coverage.

(b) A special enrollment period under s. 632.746 (6) or (7).

(19) "Network plan" means health insurance coverage of an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the insurer.

(20) "Participant" has the meaning given in section 3 (7) of the federal Employee Retirement Income Security Act of 1974. "Participant" includes an individual who is, or may become, eligible to receive a benefit, or whose beneficiaries may be eligible to receive any such benefit, in connection with a group health plan or group health benefit plan if the individual is any of the following:

(a) A partner in relation to a partnership and the group health plan or group health benefit plan is maintained by the partnership.

(b) A self–employed individual with one or more employees who are participants in the group health plan or group health benefit plan and the group health plan or group health benefit plan is maintained by the self–employed individual.

(21) "Placed for adoption" or "placement for adoption" means, with respect to the placement for adoption of a child with a person, the assumption and retention by the person of a legal obligation for the total or partial support of the child in anticipation of the adoption of the child. A child's placement for adoption with a person terminates upon the termination of the person's legal obligation for support.

(22) "Plan sponsor" has the meaning given in section 3 (16) (B) of the federal Employee Retirement Income Security Act of 1974.

(23) "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition of an individual that existed before the individual's date of enrollment for coverage.

(24) "Self–insured health plan" means a self–insured health plan of the state or a county, city, village, town or school district.

(25) "Small employer" has the meaning given in s. 635.02 (7).

(26) "Small group market" means the health insurance market under which individuals obtain health insurance coverage on behalf of themselves and their dependents, directly or through any arrangement, under a group health benefit plan maintained by, or obtained through, a small employer.

(27) "Waiting period" means, with respect to a group health plan or health insurance coverage and an individual who is a potential participant or beneficiary in the group health plan or who is potentially covered by the health insurance coverage, the period that must pass with respect to the individual before the individual is eligible for benefits under the terms of the plan or coverage.

History: 1995 a. 289, 453; 1997 a. 27; 1999 a. 9; 2001 a. 38; 2007 a. 20, 170.

632.746 Preexisting condition; portability; restrictions; and special enrollment periods. (1) (a) Subject to subs. (2) and (3), an insurer that offers a group health benefit plan may, with respect to a participant or beneficiary under the plan, impose a preexisting condition exclusion only if the exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the 6–month period ending on the participant's or beneficiary's enrollment date under the plan.

(b) A preexisting condition exclusion under par. (a) may not extend beyond 12 months, or 18 months with respect to a late enrollee, after the participant's or beneficiary's enrollment date under the plan.

(2) (a) An insurer offering a group health benefit plan may not treat genetic information as a preexisting condition under sub. (1) without a diagnosis of a condition related to the information.

(b) An insurer offering a group health benefit plan may not impose a preexisting condition exclusion relating to pregnancy as a preexisting condition.

(c) Subject to par. (e), an insurer offering a group health benefit plan may not impose a preexisting condition exclusion with respect to an individual who is covered under creditable coverage on the last day of the 30–day period beginning with the day on which the individual is born.

(d) Subject to par. (e), an insurer offering a group health benefit plan may not impose a preexisting condition exclusion with respect to an individual who is adopted or placed for adoption before attaining the age of 18 years and who is covered under creditable coverage on the last day of the 30–day period beginning with the day on which the individual is adopted or placed for adoption. This paragraph does not apply to coverage before the day on which the individual is adopted or placed for adoption.

(e) Paragraphs (c) and (d) do not apply to an individual after the end of the first continuous period during which the individual was not covered under any creditable coverage for at least 63 days. For purposes of this paragraph, any waiting period or affiliation period for coverage under a group health plan or group health benefit plan shall not be taken into account in determining the period before enrollment in the group health plan or group health benefit plan.

(3) (a) The length of time during which any preexisting condition exclusion under sub. (1) may be imposed shall be reduced by the aggregate of the participant's or beneficiary's periods of creditable coverage on his or her enrollment date under the group health benefit plan.

(b) With respect to enrollment of an individual under a group health plan or a group health benefit plan, a period of creditable coverage after which the individual was not covered under any creditable coverage for a period of at least 63 days before enrollment in the group health plan or group health benefit plan may not be counted. For purposes of this paragraph, the period specified in 2009 Wisconsin Act 11, section 9126 (2) (i), or any waiting period or affiliation period for coverage under the group health plan or group health benefit plan shall not be taken into account in determining the period before enrollment in the group health plan or group health benefit plan.

(c) No period of creditable coverage before July 1, 1996, may be counted. Individuals who need to establish creditable coverage for periods before July 1, 1996, and who would have such coverage but for this paragraph may be given credit for creditable coverage for such periods through the presentation of documents or other means provided by the federal secretary of health and human services, consistent with section 104 of P.L. 104–191.

(d) 1. An insurer offering a group health benefit plan shall count a period of creditable coverage without regard to the specific benefits for which the individual had coverage during the period.

2. Notwithstanding subd. 1., an insurer offering a group health benefit plan may elect to apply par. (a) on the basis of coverage of benefits within each of several classes or categories of benefits specified in regulations issued by the federal department of health and human services under P.L. 104–191. The election shall be made on a uniform basis for all participants and beneficiaries. Under the election, an insurer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.

3. An insurer that makes an election under subd. 2. shall prominently state in any disclosure statements concerning the coverage offered, and to each employer at the time of the offer or sale of coverage, that the insurer has made the election and what the effect of the election is.

(e) Periods of creditable coverage shall be established through the presentation of certifications described in sub. (4) or in any other manner specified in regulations issued by the federal department of health and human services under P.L. 104–191.

(4) (a) On and after October 1, 1996, an insurer that provides health benefit plan coverage shall provide the certification described in par. (b) upon the happening of any of the following events:

1. An individual ceases to be covered under the health benefit plan or otherwise becomes covered under a federal continuation provision. The certification required under this subdivision may be provided, to the extent practicable, at a time consistent with notices required under any applicable federal continuation provision or s. 632.897.

2. An individual ceases to be covered under a federal continuation provision.

3. Upon the request of an individual that is made not later than 24 months after the date of the cessation of the individual's coverage under subd. 1. or 2., whichever is later.

(b) The certification required under this subsection shall be a written certification that includes all of the following information:

1. The period of creditable coverage of the individual under the health benefit plan and the coverage, if any, under the federal continuation provision.

2. The waiting period, if any, or affiliation period, if any, imposed with respect to the individual for coverage under the health benefit plan.

(c) Upon the happening after June 30, 1996, and before October 1, 1996, of an event described in par. (a) 1. to 3., an insurer providing health benefit plan coverage shall provide a certification described in par. (b) if the individual with respect to whom the certification is provided requests the certification in writing.

(d) If an individual seeks to establish creditable coverage with respect to a period for which a certification is not required because of the happening of an event described in par. (a) 1. to 3. before July 1, 1996, all of the following apply:

1. The individual may present other credible evidence of the coverage in order to establish the period of creditable coverage.

2. An insurer may not be subject to any penalty or enforcement action with respect to the crediting or not crediting of the individual's coverage under subd. 1. if the insurer has sought to comply in good faith with any applicable requirements under this subsection.

(5) (a) If an insurer that made an election under sub. (3) (d) 2. enrolls an individual for coverage under a group health benefit plan and the individual provides a certification under sub. (4), upon the request of that insurer or the group health benefit plan the insurer that issued the certification shall promptly disclose to the requesting insurer or group health benefit plan information on coverage of classes or categories of health benefits available under the coverage on which the certification was based.

(b) The insurer providing the information may charge the requesting insurer or plan for the reasonable cost of disclosing the information.

(c) An insurer providing information under this subsection shall comply with regulations issued by the federal department of health and human services under section 2701 (e) (3) of P.L. 104–191.

(6) An insurer offering a group health benefit plan shall permit an employee who is not enrolled but who is eligible for coverage under the terms of the group health benefit plan, or a participant's or employee's dependent who is not enrolled but who is eligible for coverage under the terms of the group health benefit plan, to enroll for coverage under the terms of the plan if all of the following apply:

(a) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

(b) The employee or participant stated in writing at the time coverage was previously offered that coverage under a group health plan or health insurance coverage was the reason for declining enrollment under the insurer's group health benefit plan. This paragraph applies only if the insurer required such a statement at the time coverage was previously offered and provided the employee or participant, at the time coverage was previously offered, with notice of the requirement and the consequences of the requirement.

(c) The employee or dependent is currently covered under the group health plan or health insurance or, under the terms of the group health benefit plan, the employee or participant requests enrollment no later than 30 days after the date on which the coverage under par. (a) is exhausted or terminated.

(7) (a) If par. (b) applies, an insurer offering a group health benefit plan shall provide for a special enrollment period during which any of the following may occur:

1. A person who marries an individual and who is otherwise eligible for coverage may be enrolled under the plan as a dependent of the individual.

2. A person who is born to, adopted by or placed for adoption with, an individual may be enrolled under the plan as a dependent of the individual.

3. An individual who has met any waiting period applicable to becoming a participant under the plan, who is eligible to be enrolled under the plan and who failed to enroll during a previous enrollment period or such an individual's spouse, or both, may be enrolled under the plan.

(b) An insurer under par. (a) is required to provide for a special enrollment period if all of the following apply:

1. The group health benefit plan makes coverage available for dependents of participants under the plan.

2. The individual is a participant under the plan, or the individual has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but failed to enroll during a previous enrollment period.

3. A person becomes a dependent of the individual through marriage, birth, adoption or placement for adoption.

(c) A special enrollment period provided for under this subsection shall be for a period of not less than 30 days and shall begin on the later of either of the following:

1. The date dependent coverage is made available under the group health benefit plan.

2. The date of the marriage, birth, adoption or placement for adoption described in par. (a), whichever is applicable.

(d) If an individual seeks to enroll a dependent during the first 30 days of a special enrollment period, the coverage of the dependent shall become effective on the following date:

1. If the person becomes a dependent through marriage, not later than the first day of the first month beginning after the date on which the completed request for enrollment is received.

2. If the person becomes a dependent through birth, the date of birth.

3. If the person becomes a dependent through adoption or placement for adoption, the date of the adoption or placement for adoption.

(7m) (a) In this subsection, "terms of the group health benefit plan" does not include any requirements under the group health benefit plan related to enrollment periods or waiting periods.

(b) An insurer offering a group health benefit plan shall permit, as provided in par. (c), an employee who is not enrolled but who is eligible for coverage under the terms of the group health benefit plan, or a participant's or employee's dependent who is not enrolled but who is eligible for coverage under the terms of the group health benefit plan, to enroll for coverage under the terms of the plan if all of the following apply:

1. The employee or dependent is eligible for benefits under the Medical Assistance program under s. 49.471 or 49.472 or for

coverage under the Badger Care health care program under s. 49.665.

2. The department of health services will purchase coverage under the group health benefit plan on behalf of the employee or dependent because the department of health services has determined that paying the portion of the premium for which the employee is responsible will not be more costly than providing the medical assistance or the coverage under the Badger Care health care program, whichever is applicable.

(c) An insurer permitting an employee or dependent to enroll under this subsection shall provide for an enrollment period of not less than 30 days, beginning on the date on which the department of health services makes the determination under par. (b) 2.

(8) (a) A health maintenance organization that offers a group health benefit plan and that does not impose any preexisting condition exclusion under sub. (1) with respect to a particular coverage option may impose an affiliation period for that coverage option, but only if all of the following apply:

1. The affiliation period is applied uniformly without regard to any health status–related factors.

2. The affiliation period does not exceed 2 months, or 3 months with respect to a late enrollee.

(b) A health maintenance organization that imposes an affiliation period under this subsection is not required to provide health care services or benefits during the affiliation period. A health maintenance organization may not charge a premium to a participant or beneficiary for any coverage that is provided during an affiliation period. An affiliation period shall begin on the enrollment date and run concurrently with any waiting period under the group health benefit plan.

(c) A health maintenance organization under par. (a) may use methods other than those described in par. (a) to address adverse selection, if the methods are approved by the commissioner.

(9) (a) Except as provided in pars. (b) and (c), requirements used by an insurer in determining whether to provide coverage under a group health benefit plan to an employer, including requirements for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all employers that apply for or receive coverage from the insurer.

(b) An insurer may do all of the following:

1. Vary its minimum participation requirements or minimum employer contribution requirements only by the size of the employer group based on the number of eligible employees.

2. Unless the commissioner by rule permits more frequent change, increase the minimum participation requirements or minimum employer contribution requirements no more than one time during a calendar year and, except as otherwise permitted under this subsection, only if the requirements are applied uniformly to all employers applying for coverage and to all renewing employers effective on the date of renewal.

3. Except as limited or restricted by rule of the commissioner, establish separate participation requirements or employer contribution requirements that uniformly apply to all employers that provide a choice of coverage to employees or their dependents. Except as limited or restricted by rule of the commissioner, an insurer may establish separate uniform requirements based on the number or type of choice of coverage provided by the employer.

(c) Except as provided in par. (b), an insurer may vary requirements used by the insurer in determining whether to provide coverage under a group health benefit plan to a large employer, but only if the requirements are applied uniformly among all large employers that have the same number of eligible employees.

(d) In applying minimum participation requirements with respect to an employer, an insurer may not count eligible employees who have other coverage that is creditable coverage in determining whether the applicable percentage of participation is met, except that an insurer may count eligible employees who have coverage under another health benefit plan that is sponsored by that employer and that is creditable coverage.

(e) This subsection does not apply to a group health benefit plan offered by the state under s. 40.51 (6) or by the group insurance board under s. 40.51 (7).

(10) (a) 1. Except as provided in rules promulgated under subd. 3. or 4., if an insurer offers a group health benefit plan to an employer, the insurer shall offer coverage to all of the eligible employees of the employer and their dependents. Except as provided in rules promulgated under subd. 3. or 4., an insurer may not offer coverage to only certain individuals in an employer group or to only part of the group, except for an eligible employee who has not yet satisfied an applicable waiting period, if any.

2. Except as provided in rules promulgated under subd. 3., if the state or a county, city, village, town or school district offers coverage under a self–insured health plan, it shall offer coverage to all of its eligible employees and their dependents. Except as provided in rules promulgated under subd. 3., the state or a county, city, village, town or school district may not offer coverage to only certain individuals in the employer group or to only part of the group, except for an eligible employee who has not yet satisfied an applicable waiting period, if any.

3. The secretary of employee trust funds, with the approval of the group insurance board, shall promulgate rules related to offering coverage to eligible employees under a group health benefit plan, or a self–insured health plan, offered by the state under s. 40.51 (6) or by the group insurance board under s. 40.51 (7). The rules shall conform to the intent of subds. 1. and 2. and may not allow the state or the group insurance board to refuse to offer coverage to an eligible employee or dependent for reasons related to health condition.

4. The commissioner may promulgate rules permitting exceptions to the requirement under subd. 1. for classes of eligible employees or their dependents. No rule promulgated under this subdivision may permit an insurer to refuse to offer to provide coverage to an eligible employee or his or her dependent for reasons related to health condition.

(b) 1. An insurer may not modify a group health benefit plan with respect to an employer or an eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the group health benefit plan.

2. The state or a county, city, village, town or school district may not modify a self–insured health plan with respect to an eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the self–insured health plan.

3. Nothing in this paragraph limits the authority of the group insurance board to fulfill its obligations as trustee under s. 40.03 (6) (d) or to design or modify procedures or provisions pertaining to enrollment, premium transmitted or coverage of eligible employees for health care benefits under s. 40.51 (1).

History: 1997 a. 27; 2003 a. 33; 2007 a. 20 ss. 3679, 9121 (6) (a); 2009 a. 11.

632.747 Guaranteed acceptance. **(1)** EMPLOYEE BECOMES ELIGIBLE AFTER COMMENCEMENT OF COVERAGE. Unless otherwise permitted by rule of the commissioner, if an insurer provides coverage under a group health benefit plan, the insurer shall provide coverage under the group health benefit plan to an eligible employee who becomes eligible for coverage after the commencement of the employer's coverage, and to the eligible employee's dependents, regardless of health condition or claims experience, if all of the following apply:

(a) The employee has satisfied any applicable waiting period.

(b) The employer agrees to pay the premium required for coverage of the employee under the group health benefit plan.

(3) STATE OR MUNICIPAL SELF–INSURED PLANS. If the state or a county, city, village, town or school district provides coverage under a self–insured health plan, it shall provide coverage under

the self–insured health plan to an eligible employee who waived coverage during an enrollment period during which the employee was entitled to enroll in the self–insured health plan, regardless of health condition or claims experience, if all of the following apply:

(a) The eligible employee was covered as a dependent under creditable coverage when he or she waived coverage under the self–insured health plan.

(b) The eligible employee's coverage under the creditable coverage has terminated or will terminate due to a divorce from the insured under the creditable coverage, the death of the insured under the creditable coverage, loss of employment by the insured under the creditable coverage or involuntary loss of coverage under the creditable coverage by the insured under the creditable coverage.

(c) The eligible employee applies for coverage under the self–insured health plan not more than 30 days after termination of his or her coverage under the creditable coverage.

History: 1995 a. 289; 1997 a. 27.

632.748 Prohibiting discrimination. (1) (a) Subject to subs. (3) and (4), an insurer may not establish rules for the eligibility of any individual to enroll, or for the continued eligibility of any individual to remain enrolled, under a group health benefit plan based on any of the following factors with respect to the individual or a dependent of the individual:

1. Health status.

2. Medical condition, including both physical and mental illnesses.

3. Claims experience.

4. Receipt of health care.

5. Medical history.

6. Genetic information.

7. Evidence of insurability, including conditions arising out of acts of domestic violence.

8. Disability.

(b) For purposes of par. (a), rules for eligibility to enroll under a group health benefit plan include rules defining any applicable waiting periods for enrollment.

(2) An insurer offering a group health benefit plan may not require any individual, as a condition of enrollment or continued enrollment under the plan, to pay, on the basis of any health status–related factor with respect to the individual or a dependent of the individual, a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled under the plan.

(3) To the extent consistent with s. 632.746, sub. (1) shall not be construed to do any of the following:

(a) Require a group health benefit plan to provide particular benefits other than those provided under the terms of the plan.

(b) Prevent a group health benefit plan from establishing limitations or restrictions on the amount, level, extent or nature of benefits or coverage for similarly situated individuals enrolled under the plan.

(4) Nothing in sub. (1) shall be construed to do any of the following:

(a) Restrict the amount that an insurer may charge an employer for coverage under a group health benefit plan.

(b) Prevent an insurer offering a group health benefit plan from establishing premium discounts or rebates, or from modifying otherwise applicable copayments or deductibles, in return for adherence to programs of health promotion and disease prevention.

(c) Provide an exception from, or limit, the rate regulation under s. 635.05.

History: 1997 a. 27.

632.749 Contract termination and renewability. (1) (a) Except as provided in subs. (2) to (4) and notwithstanding s. 631.36 (2) to (4m), an insurer that offers a group health benefit plan shall renew such coverage or continue such coverage in force at the option of the employer and, if applicable, plan sponsor.

(b) At the time of coverage renewal, the insurer may modify a group health benefit plan issued in the large group market.

(2) Notwithstanding s. 631.36 (2) to (4m), an insurer may nonrenew or discontinue a group health benefit plan, but only if any of the following applies:

(a) The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the group health benefit plan or in a timely manner.

(b) The plan sponsor has performed an act or engaged in a practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(c) The plan sponsor has failed to comply with a material plan provision that is permitted under law relating to employer contribution or group participation rules.

(d) The insurer is ceasing to offer coverage in the market in which the group health benefit plan is included in accordance with sub. (3) and any other applicable state law.

(e) In the case of a group health benefit plan that the insurer offers through a network plan, there is no longer an enrollee under the plan who resides, lives or works in the service area of the insurer or in an area in which the insurer is authorized to do business and, in the case of the small group market, the insurer would deny enrollment under the plan under s. 635.19 (2) (a) 1.

(f) In the case of a group health benefit plan that is made available only through one or more bona fide associations, the employer ceases to be a member of the association on which the coverage is based. Coverage may be terminated if this paragraph applies only if the coverage is terminated uniformly without regard to any health status–related factor of any covered individual.

(3) (a) Notwithstanding s. 631.36 (2) to (4m), an insurer may discontinue offering in this state a particular type of group health benefit plan offered in either the large group market or the group market other than the large group market, but only if all of the following apply:

1. The insurer provides notice of the discontinuance to each employer and, if applicable, plan sponsor for whom the insurer provides coverage of this type in this state, and to the participants and beneficiaries covered under the coverage, at least 90 days before the date on which the coverage will be discontinued.

2. The insurer offers to each employer and, if applicable, plan sponsor for whom the insurer provides coverage of this type in this state the option to purchase from among all of the other group health benefit plans that the insurer offers in the market in which is included the type of group health benefit plan that is being discontinued, except that in the case of the large group market, the insurer must offer each employer and, if applicable, plan sponsor the option to purchase one other group health benefit plan that the insurer offers in the large group market.

3. In exercising the option to discontinue coverage of this particular type and in offering the option to purchase coverage under subd. 2., the insurer acts uniformly without regard to any health status–related factor of any covered participants or beneficiaries or any participants or beneficiaries who may become eligible for coverage.

(b) Notwithstanding s. 631.36 (2) to (4m), an insurer may discontinue offering in this state all group health benefit plans in the large group market or in the group market other than the large group market, or in both such group markets, but only if all of the following apply:

1. The insurer provides notice of the discontinuance to the commissioner and to each employer and, if applicable, plan spon-

sor for whom the insurer provides coverage of this type in this state, and to the participants and beneficiaries covered under the coverage, at least 180 days before the date on which the coverage will be discontinued.

2. All group health benefit plans issued or delivered for issuance in this state in the affected market or markets are discontinued and coverage under such group health benefit plans is not renewed.

3. The insurer does not issue or deliver for issuance in this state any group health benefit plan in the affected market or markets before 5 years after the day on which the last group health benefit plan is discontinued under subd. 2.

(4) This section does not apply to a group health benefit plan offered by the state under s. 40.51 (6) or by the group insurance board under s. 40.51 (7).

History: 1995 a. 289; 1997 a. 27.

632.7495 Guaranteed renewability of individual health insurance coverage. (1) (a) Except as provided in subs. (2) to (4) and notwithstanding s. 631.36 (2) to (4m), an insurer that provides individual health benefit plan coverage shall renew such coverage or continue such coverage in force at the option of the insured individual and, if applicable, the association through which the individual has coverage.

(b) At the time of coverage renewal, the insurer may modify the individual health benefit plan coverage policy form as long as the modification is consistent with state law and effective on a uniform basis among all individuals with coverage under that policy form.

(2) Notwithstanding s. 631.36 (2) to (4m), an insurer may nonrenew or discontinue the individual health benefit plan coverage of an individual, but only if any of the following applies:

(a) The individual or, if applicable, the association through which the individual has coverage has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or in a timely manner.

(b) The individual or, if applicable, the association through which the individual has coverage has performed an act or engaged in a practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the health insurance coverage.

(c) The insurer is ceasing to offer individual health benefit plan coverage in accordance with sub. (3) and any other applicable state law.

(d) In the case of individual health benefit plan coverage that the insurer offers through a network plan, the individual no longer resides, lives or works in the service area or in an area in which the insurer is authorized to do business. Coverage may be terminated if this paragraph applies only if the coverage is terminated uniformly without regard to any health status–related factor of covered individuals.

(e) In the case of individual health benefit plan coverage that the insurer offers only through one or more bona fide associations, the individual ceases to be a member of the association on which the coverage is based. Coverage may be terminated if this paragraph applies only if the coverage is terminated uniformly without regard to any health status–related factor of covered individuals.

(f) The individual is eligible for medicare and the commissioner by rule permits coverage to be terminated.

(3) (a) Notwithstanding s. 631.36 (2) to (4m), an insurer may discontinue offering in this state a particular type of individual health benefit plan coverage, but only if all of the following apply:

1. The insurer provides notice of the discontinuance to each individual for whom the insurer provides coverage of this type in this state and, if applicable, to the association through which the individual has coverage at least 90 days before the date on which the coverage will be discontinued.

2. The insurer offers to each individual for whom the insurer provides coverage of this type in this state and, if applicable, to the association through which the individual has coverage the option to purchase any other type of individual health insurance coverage that the insurer offers for individuals.

3. In electing to discontinue coverage of this particular type and in offering the option to purchase coverage under subd. 2., the insurer acts uniformly without regard to any health status–related factor of enrolled individuals or individuals who may become eligible for the type of coverage described under subd. 2.

(b) Notwithstanding s. 631.36 (2) to (4m), an insurer may discontinue offering individual health benefit plan coverage in this state, but only if all of the following apply:

1. The insurer provides notice of the discontinuance to the commissioner and to each individual for whom the insurer provides individual health benefit plan coverage in this state and, if applicable, to the association through which the individual has coverage at least 180 days before the date on which the coverage will be discontinued.

2. All individual health benefit plan coverage issued or delivered for issuance in this state is discontinued and coverage under such coverage is not renewed.

3. The insurer does not issue or deliver for issuance in this state any individual health benefit plan coverage before 5 years after the day on which the last individual health benefit plan coverage is discontinued under subd. 2.

(4) Except as the commissioner may provide by rule under sub. (5) and notwithstanding subs. (1) and (2) and s. 631.36 (4), an insurer is not required to renew individual health benefit plan coverage that complies with all of the following:

(a) The coverage is marketed and designed to provide short–term coverage as a bridge between coverages.

(b) The coverage has a term of not more than 12 months.

(c) The coverage term aggregated with all consecutive periods of the insurer's coverage of the insured by individual health benefit plan coverage not required to be renewed under this subsection does not exceed 18 months. For purposes of this paragraph, coverage periods are consecutive if there are no more than 63 days between the coverage periods.

(d) Rules promulgated by the commissioner under sub. (5).

(5) The commissioner shall promulgate rules governing disclosures related to, and may promulgate rules setting standards for, the sale of individual health benefit plans that an insurer is not required to renew under sub. (4).

History: 1997 a. 27, 237; 2009 a. 28.

632.7497 Modifications at renewal. (1) In this section, "individual major medical or comprehensive health benefit plan" includes coverage under a group policy that is underwritten on an individual basis and issued to individuals or families.

(2) An insurer that issues an individual major medical or comprehensive health benefit plan shall, at the time of a coverage renewal, at the request of an insured, permit the insured to do either of the following:

(a) Change his or her coverage to any of the following:

1. A different but comparable individual major medical or comprehensive health benefit plan currently offered by the insurer.

2. An individual major medical or comprehensive health benefit plan currently offered by the insurer with more limited benefits.

3. An individual major medical or comprehensive health benefit plan currently offered by the insurer with higher deductibles.

(b) Modify his or her existing coverage by electing an optional higher deductible, if any, under the individual major medical or comprehensive health benefit plan.

(3) (a) The insurer may not impose any new preexisting condition exclusion under the new or modified coverage under sub. (2) that did not apply to the insured's original coverage and shall allow the insured credit under the new or modified coverage for the period of original coverage.

(b) For the new or modified coverage, the insurer may not rate for health status other than on the insured's health status at the time the insured applied for the original coverage and as the insured disclosed on the original application.

(4) (a) Annually, the insurer shall mail to each insured under an individual major medical or comprehensive health benefit plan issued by the insurer, a notice that includes all of the following information:

1. That the insured has the right to elect alternative coverage as described in sub. (2).

2. A description of the alternatives available to the insured.

3. The procedure for making the election.

(b) The insurer shall mail the notice under par. (a) not more than 3 months nor less than 60 days before the renewal date of the insured's plan.

(5) (a) Nothing in this section requires an insurer to issue alternative coverage under sub. (2) if the insured's coverage may be nonrenewed or discontinued under s. 632.7495 (2), (3) (b), or (4).

(b) Notwithstanding s. 600.01 (1) (b) 3. and 4., this section applies to a group health benefit plan described in s. 600.01 (1) (b) 3. or 4. if that group health benefit plan is an individual major medical or comprehensive health benefit plan as defined in sub. (1).

History: 2009 a. 28.

632.75 Prohibited provisions for disability insurance. (1) DEATH PRESUMED FROM EXTENDED ABSENCE. Section 813.22 (1) applies to any disability insurance policy providing a death benefit.

(2) DIVIDENDS CONDITIONED ON CONTINUATION OF POLICY OR PAYMENT OF PREMIUMS. Except on the first or second anniversary, no dividend payable on a disability insurance policy may be made contingent on the continuation of the policy or on premium payments.

(3) PROHIBITION OF EXCLUSION FROM COVERAGE OF CERTAIN DEPENDENT CHILDREN. No disability insurance policy issued or renewed on or after April 30, 1980, may exclude or terminate from coverage any dependent child of an insured person or group member solely because the child does not reside with the insured person or group member. This subsection does not apply to a group policy, as defined in s. 632.897 (1) (c), or an individual policy, as defined in s. 632.897 (1) (cm), that is subject to s. 632.897 (10).

(4) OUT–OF–STATE SERVICE PROVIDERS. Except as provided in s. 628.36, no disability insurance policy may exclude or limit coverage of health care services provided outside this state, if the services are provided within 75 miles of the insured's residence in a facility licensed or approved by the state where the facility is located.

(5) PAYMENTS FOR HOSPITAL SERVICES. No insurer may reimburse a hospital for patient health care costs at a rate exceeding the rate established under ch. 54, 1985 stats., or s. 146.60, 1983 stats., for care provided prior to July 1, 1987.

History: 1975 c. 375; 1979 c. 221; 1981 c. 304; 1983 a. 27; 1985 a. 29 s. 3202 (27); 1987 a. 27; 1989 a. 31, 359.

632.755 Public assistance and early intervention services. (1g) (a) A disability insurance policy may not exclude a person or a person's dependent from coverage because the person or the dependent is eligible for assistance under ch. 49 or because the dependent is eligible for early intervention services under s. 51.44.

(b) A disability insurance policy may not terminate its coverage of a person or a person's dependent because the person or the dependent is eligible for assistance under ch. 49 or because the dependent is eligible for early intervention services under s. 51.44.

(c) A disability insurance policy may not provide different benefits of coverage to a person or the person's dependent because the person or the dependent is eligible for assistance under ch. 49 or because the dependent is eligible for early intervention services under s. 51.44 than it provides to persons and their dependents who are not eligible for assistance under ch. 49 or for early intervention services under s. 51.44.

(2) Benefits provided by a disability insurance policy shall be primary to those benefits provided under ch. 49 or under s. 51.44 or 253.05.

History: 1985 a. 29; 1989 a. 173; 1991 a. 178, 214; 1995 a. 407; 1997 a. 27.

632.76 Incontestability for disability insurance. (1) AVOIDANCE FOR MISREPRESENTATIONS. No statement made by an applicant in the application for individual disability insurance coverage and no statement made respecting the person's insurability by a person insured under a group policy, except fraudulent misrepresentation, is a basis for avoidance of the policy or denial of a claim for loss incurred or disability commencing after the coverage has been in effect for 2 years. The policy may provide for incontestability even with respect to fraudulent misstatements.

(2) PREEXISTING DISEASES. (a) No claim for loss incurred or disability commencing after 2 years from the date of issue of the policy may be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of coverage, unless the condition was excluded from coverage by name or specific description by a provision effective on the date of loss. This paragraph does not apply to a group health benefit plan, as defined in s. 632.745 (9), which is subject to s. 632.746.

(ac) 1. Notwithstanding par. (a), no claim or loss incurred or disability commencing after 12 months from the date of issue of an individual disability insurance policy, as defined in s. 632.895 (1) (a), may be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of coverage, unless the condition was excluded from coverage by name or specific description by a provision effective on the date of the loss.

2. Except as provided in subd. 3., an individual disability insurance policy, as defined in s. 632.895 (1) (a), other than a short–term policy subject to s. 632.7495 (4) and (5), may not define a preexisting condition more restrictively than a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within 12 months before the effective date of coverage.

3. Except as the commissioner provides by rule under s. 632.7495 (5), all of the following apply to an individual disability insurance policy that is a short–term policy subject to s. 632.7495 (4) and (5):

a. The policy may not define a preexisting condition more restrictively than a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received before the effective date of coverage.

b. The policy shall reduce the length of time during which a preexisting condition exclusion may be imposed by the aggregate of the insured's consecutive periods of coverage under the insurer's individual disability insurance policies that are short–term policies subject to s. 632.7495 (4) and (5). For purposes of this subd. 3. b., coverage periods are consecutive if there are no more than 63 days between the coverage periods.

(b) Notwithstanding par. (a), no claim for loss incurred or disability commencing after 6 months from the date of issue of a medicare supplement policy, medicare replacement policy or long–term care insurance policy may be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of coverage. Notwithstanding par. (ac) 2., a medicare supplement policy, medicare replacement policy, or long–term care insurance policy may not define a preexisting condition

more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage. Notwithstanding par. (a), if on the basis of information contained in an application for insurance a medicare supplement policy, medicare replacement policy, or long–term care insurance policy excludes from coverage a condition by name or specific description, the exclusion must terminate no later than 6 months after the date of issue of the medicare supplement policy, medicare replacement policy, or long–term care insurance policy. The commissioner may by rule exempt from this paragraph certain classes of medicare supplement policies, medicare replacement policies, and long–term care insurance policies, if the commissioner finds the exemption is not adverse to the interests of policyholders and certificate holders.

History: 1975 c. 375, 421; 1981 c. 82; 1985 a. 29; 1989 a. 31; 1995 a. 289; 1997 a. 27; 2009 a. 28.

Cross–reference: See also s. Ins 3.39, Wis. adm. code.

A generic exclusion of all diseases or conditions diagnosed or treated before issuance of the policy does not constitute exclusion by "name or specific description" under sub. (2). Peterson v. Equitable Life Assurance Society, 57 F. Supp. 2d 692 (1999).

632.77 Permitted provisions for disability insurance policies. If any provisions are contained in a disability insurance policy dealing with the following subjects, they shall conform to the requirements specified:

(1) CHANGE OF OCCUPATION. Any provision respecting change of occupation may provide only for a lower maximum payment and for reduction of loss payments proportionate to the change in appropriate premium rates if the change is to a higher rated occupation, and must provide for retroactive reduction of premium rates from the date of change of occupation or the last policy anniversary date, whichever is the more recent, if the change is to a lower rated occupation.

(2) MISSTATEMENT OF AGE. Any provision respecting misstatement of age may only provide for reduction of the loss payable to the amount that the premium paid would have purchased at the correct age.

(3) LIMITATIONS ON PAYMENTS. Any limitation on payments because of other insurance or because of the income of the insured must be in accordance with provisions approved by the commissioner by rule or explicitly approved in approving the policy form, but the commissioner may not promulgate a rule that conflicts with s. 632.755 nor approve a policy form that does not comply with s. 632.755.

(4) FACILITY OF PAYMENT. Reasonable facility of payment clauses may be inserted. Payment in accordance with such clauses shall discharge the insurer's obligation to pay claims.

History: 1975 c. 375; 1979 c. 102; 1985 a. 29.

632.775 Effect of power of attorney for health care. **(1)** INSURER MAY NOT REQUIRE. An insurer may not require an individual to execute a power of attorney for health care under ch. 155 as a condition of coverage under a disability insurance policy.

(2) EFFECT ON DISABILITY POLICIES. Executing a power of attorney for health care under ch. 155 may not be used to impair in any manner the procurement of a disability insurance policy or to modify the terms of an existing disability insurance policy. A disability insurance policy may not be impaired or invalidated in any manner by the exercise of a health care decision by a health care agent on behalf of a person who is insured under the policy and who has authorized the health care agent under ch. 155.

History: 1989 a. 200.

632.78 Required grace period for disability insurance policies. Every disability insurance policy shall contain clauses providing for a grace period of at least 7 days for weekly premium policies, 10 days for monthly premium policies and 31 days for all other policies, for each premium after the first, during which the policy shall continue in force. In group and blanket policies the policy must provide for a grace period of at least 31 days unless the policyholder gives written notice of discontinuance prior to the date of discontinuance and in accordance with the policy terms. In group or blanket policies, the policy may provide for payment of a proportional premium for the period the policy is in effect during the grace period under this section.

History: 1975 c. 375; 1977 c. 371; 1979 c. 75; 1979 c. 110 s. 60 (11); 1979 c. 221; 1981 c. 39.

632.79 Notice of termination of group hospital, surgical or medical expense insurance coverage due to cessation of business or default in payment of premiums. **(1)** SCOPE. This section shall apply to every group hospital, surgical or medical expense insurance policy or service plan purchased by or on behalf of an employer to provide coverage for employees and issued under s. 185.981 or by any insurer authorized under chs. 600 to 646 which has been delivered, renewed or is otherwise in force on or after June 12, 1976.

(2) NOTICE TO POLICYHOLDER OR PARTY RESPONSIBLE FOR PAYMENT OF PREMIUMS. (a) Prior to termination of any group policy, plan or coverage subject to this section due to a cessation of business or default in payment of premiums by the policyholder, trust, association or other party responsible for such payment, the insurer or organization issuing the policy, contract, booklet or other evidence of insurance shall notify in writing the policyholder, trust, association or other party responsible for payment of premiums of the date as of which the policy or plan will be terminated or discontinued. At such time, the insurer or organization shall additionally furnish to the policyholder, trust, association or other party a notice form in sufficient number to be distributed to covered employees or members indicating what rights, if any, are available to them upon termination.

(b) For purpose of notice and distribution to covered employees and members under par. (a), the administrator responsible for determining the persons covered and the premiums payable to the insurer or organization under any group policy or plan of disability insurance is responsible for providing such notices.

(3) LIABILITY OF INSURER OR SERVICE ORGANIZATION FOR PAYMENT OF CLAIMS. Under any group policy or plan subject to this section, the insurer or organization shall be liable for all valid claims for covered losses prior to the expiration of any grace period specified in the group policy or plan.

(5) NOTICE EXCEPTION. The notice requirements of this section shall not apply if a group policy or plan providing coverage to employees or members is terminated and immediately replaced by another policy or plan providing similar coverage to such employees or members.

History: 1975 c. 352; Stats. 1975 s. 204.324; 1975 c. 422 s. 106; Stats. 1975 s. 632.79; 1979 c. 32, 221.

Cross–reference: See also s. Ins 6.51, Wis. adm. code.

632.793 Notice of loss of primary insurance coverage due to age. **(1)** NOTICE TO INSURED AND EMPLOYER. If an individual who is covered under a group disability insurance policy, as defined in s. 632.895 (1) (a), that is purchased by or on behalf of an employer to provide coverage for employees will lose primary coverage under the policy upon reaching age 65, the insurer issuing the policy shall provide written notice of the change in coverage status by regular mail to the individual and shall send a copy of the notice by regular mail to the employer. The insurer shall provide the notice not less than 30 nor more than 60 days before the individual becomes 65 years of age. The notice shall specify the date on which the insurance coverage will no longer be primary and shall inform the individual that he or she will be eligible for coverage under the federal medicare program at age 65.

(2) APPLICABILITY. Subsection (1) does not apply if the employer has at least 20 employees for each working day in at least 20 calendar weeks in the current year or the preceding year.

History: 1993 a. 108.

632.795 Open enrollment upon liquidation. **(1)** DEFINITION. In this section, "liquidated insurer" means an insurer

ordered liquidated under ch. 645 or under similar laws of another jurisdiction.

(2) COVERAGE FOR GROUP MEMBERS. Except as provided in sub. (5) and unless otherwise provided by rule or order of the commissioner, an insurer described in sub. (3) shall permit insureds or enrolled participants of a liquidated insurer's group health care policy or plan to obtain coverage under a comprehensive group health care policy or plan offered by the insurer in the manner and under the terms required by sub. (4).

(3) PARTICIPATING INSURERS. Subsection (2) applies to an insurer that participated in the most recent enrollment period in which the group members were able to choose among coverage offered by the liquidated insurer and coverage offered by one or more other insurers, if all of the following are satisfied:

(a) Coverage under a comprehensive group health care policy or plan offered by the insurer was selected by one or more members of the group in the most recent enrollment period.

(b) The most recent enrollment period occurred on or after July 1, 1989.

(4) TERMS AND OFFERING OF COVERAGE. (a) An insurer subject to sub. (2) shall provide coverage under the same policy form and for the same premium as it originally offered in the most recent enrollment period, subject only to the medical underwriting used in that enrollment period. Unless otherwise prescribed by rule, the insurer may apply deductibles, preexisting condition limitations, waiting periods or other limits only to the extent that they would have been applicable had coverage been extended at the time of the most recent enrollment period and with credit for the satisfaction or partial satisfaction of similar provisions under the liquidated insurer's policy or plan. The insurer may exclude coverage of claims that are payable by a solvent insurer under insolvency coverage required by the commissioner or by the insurance regulator of another jurisdiction. Coverage shall be effective on the date that the liquidated insurer's coverage terminates.

(b) An insurer subject to sub. (2) shall offer coverage to the group members, and the policyholder shall provide group members with the opportunity to obtain coverage, in the manner and within the time limits required by the commissioner by rule or order.

(5) MEDICAL ASSISTANCE ENROLLEES. This section does not apply to persons enrolled in a health care plan offered by a liquidated insurer if the persons are enrolled in that plan under a contract between the department of health services and the liquidated insurer under s. 49.45 (2) (b) 2.

History: 1989 a. 23; 1995 a. 27 s. 9126 (19); 2007 a. 20 s. 9121 (6) (a).

632.797 Disclosure of group health claims experience. (1) (a) Except as provided in subs. (2) and (3), an insurer shall provide the policyholder of a group or blanket disability insurance policy, or an employer that provides health care coverage to its employees through a multiple–employer trust, with the policyholder's or the employer's aggregate group health claims experience for the current policy period, and for up to 2 policy periods immediately preceding the current policy period if the insurer provided coverage during those periods, upon request from the policyholder or employer.

(b) The insurer shall provide the information under par. (a) no later than 30 days after receiving a request for that information from the policyholder or employer.

(c) The insurer may not charge the policyholder or the employer for providing the information under par. (a) one time in a 12–month period.

(d) Except for charging a fee under par. (c), an insurer may not change the rating methodology between community rating and experience rating or otherwise penalize a policyholder or employer for requesting the information under par. (a).

(2) An insurer is not required to provide the information under sub. (1) unless the policyholder or employer requesting the information provides coverage under the policy for at least 50 individuals, exclusive of individuals who have coverage under the policy as a dependent of another individual.

(3) Notwithstanding sub. (1), an insurer is not required to provide health claims experience under sub. (1) for any period of time that is before 18 months before the date on which the information is requested.

(4) Subsection (1) does not require that an insurer provide the policyholder of a group or blanket disability insurance policy, or an employer that provides health care coverage to its employees through a multiple–employer trust, with the health claims experience of an individual employee or insured.

(5) An insurer is not required under sub. (1) to provide information that identifies an individual or that is confidential under s. 146.82.

(6) An insurer that provides aggregate health claims experience information in compliance with this section is immune from civil liability for its acts or omissions in providing such information.

History: 1993 a. 448; 2011 a. 32.

632.798 Out–of–pocket costs. (1) DEFINITIONS. In this section:

(a) "Disability insurance policy" has the meaning given in s. 632.895 (1) (a).

(b) "Health care provider" has the meaning given in s. 146.903 (1) (c) and includes a hospital, as defined in s. 50.33 (2).

(c) "Insured" includes an enrollee under a self–insured health plan and a representative or designee of an insured or enrollee.

(d) "Self–insured health plan" means a self–insured health plan of the state or a county, city, village, town, or school district.

(2) PROVIDE ESTIMATE. (a) A self–insured health plan or an insurer that provides coverage under a disability insurance policy shall, at the request of an insured, provide to the insured a good faith estimate, as of the date of the request and assuming no medical complications or modifications in the insured's treatment plan, of the insured's total out–of–pocket cost according to the insured's benefit terms for a specified health care service in the geographic region in which the health care service will be provided.

(b) An estimate provided by an insurer or self–insured health plan under this section is not a legally binding estimate of the out–of–pocket cost.

(c) An insurer or self–insured health plan may not charge an insured for providing the information under this section.

(d) Before providing the information requested under par. (a), the insurer or self–insured health plan may require the insured to provide in writing any of the following information:

1. The name of the health care provider providing the service.

2. The facility at which the service will be provided.

3. The date the service will be provided.

4. The health care provider's estimate of the charge for the service.

5. The codes for the service under the Current Procedural Terminology of the American Medical Association or under the Current Dental Terminology of the American Dental Association.

(e) The requirement to provide the information requested under par. (a) does not apply if the health care provider providing the health care service is any of the following:

1. A health care provider that practices individually or in association with not more than 2 other individual health care providers.

2. A health care provider that is an association of 3 or fewer individual health care providers.

History: 2009 a. 146.

632.80 Restrictions on medical payments insurance. The provisions of this subchapter do not apply to medical payments insurance when it is a part of or supplemental to liability, steam boiler, elevator, automobile or other insurance covering loss of or damage to property, provided the loss, damage or

expense arises out of a hazard directly related to such other insurance.

History: 1975 c. 375.

632.81 Minimum standards for certain disability policies. The commissioner may by rule establish minimum standards for benefits, claims payments, marketing practices, compensation arrangements and reporting practices for medicare supplement policies, medicare replacement policies and long–term care insurance policies. The commissioner may by rule exempt from the minimum standards certain types of coverage, if the commissioner finds the exemption is not adverse to the interests of policyholders and certificate holders.

History: 1981 c. 82; 1985 a. 29; 1989 a. 31, 332.

Cross–reference: See also ss. Ins 3.39, 3.455, and 3.46, Wis. adm. code.

632.82 Renewability of long–term care insurance policies. Notwithstanding s. 631.36 (2) to (5), the commissioner shall, by rule, require long–term care insurance policies that are issued on an individual basis to include a provision restricting the insurer's ability to terminate or alter the long–term care insurance policy except for nonpayment of premium. The rule may specify exceptions to the restriction, including exceptions that allow insurers to do any of the following:

(1) Change the rates charged on a long–term care insurance policy if the rate change is made on a class basis.

(2) Refuse to renew a long–term care insurance policy if conditions specified in the rule are satisfied. The conditions shall, at a minimum, require all of the following:

(a) That the nonrenewal be on other than an individual basis.

(b) That the insurer demonstrate to the commissioner that renewal will affect the insurer's solvency or loss experience as specified in the rule.

History: 1989 a. 31.

632.825 Midterm termination of long–term care insurance policy by insured. (1) PERMITTED CANCELLATION AND REFUND. (a) No insurer that provides coverage under a long–term care insurance policy may prohibit the insured under the policy from canceling the policy before the expiration of the agreed term.

(b) If an insured under a long–term care insurance policy cancels the policy before the expiration of the agreed term, the insurer shall issue a prorated premium refund to the insured.

(c) If an insured under a long–term care insurance policy dies during the term of the policy, the insurer shall issue a prorated premium refund to the insured's estate.

(2) POLICY PROVISION. Every long–term care insurance policy shall contain a provision that apprises the insured of the insured's right to cancel and the insurer's premium refund responsibilities under sub. (1).

History: 1993 a. 207.

Cross–reference: See also ss. Ins 3.455 and 3.46, Wis. adm. code.

632.83 Internal grievance procedure. (1) In this section, "health benefit plan" has the meaning given in s. 632.745 (11), except that "health benefit plan" includes the coverage specified in s. 632.745 (11) (b) 10. and includes a policy, certificate or contract under s. 632.745 (11) (b) 9. that provides only limited–scope dental or vision benefits.

(2) Every insurer that issues a health benefit plan shall do all of the following:

(a) Establish and use an internal grievance procedure that is approved by the commissioner and that complies with sub. (3) for the resolution of insureds' grievances with the health benefit plan.

(b) Provide insureds with complete and understandable information describing the internal grievance procedure under par. (a).

(c) Submit an annual report to the commissioner describing the internal grievance procedure under par. (a) and summarizing the experience under the procedure for the year.

(3) The internal grievance procedure established under sub. (2) (a) shall include all of the following elements:

(a) The opportunity for an insured to submit a written grievance in any form.

(b) Establishment of a grievance panel for the investigation of each grievance submitted under par. (a), consisting of at least one individual authorized to take corrective action on the grievance and at least one insured other than the grievant, if an insured is available to serve on the grievance panel.

(c) Prompt investigation of each grievance submitted under par. (a).

(d) Notification to each grievant of the disposition of his or her grievance and of any corrective action taken on the grievance.

(e) Retention of records pertaining to each grievance for at least 3 years after the date of notification under par. (d).

History: 1999 a. 155 ss. 8 to 17; Stats. 1999 s. 632.83.

632.835 Independent review of coverage denial determinations. (1) DEFINITIONS. In this section:

(a) "Adverse determination" means a determination by or on behalf of an insurer that issues a health benefit plan to which all of the following apply:

1. An admission to a health care facility, the availability of care, the continued stay or other treatment that is a covered benefit has been reviewed.

2. Based on the information provided, the treatment under subd. 1. does not meet the health benefit plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.

3. Based on the information provided, the insurer that issued the health benefit plan reduced, denied or terminated the treatment under subd. 1. or payment for the treatment under subd. 1.

4. Subject to sub. (5) (c), the amount of the reduction or the cost or expected cost of the denied or terminated treatment or payment exceeds, or will exceed during the course of the treatment, $250.

(ag) "Coverage denial determination" means an adverse determination, an experimental treatment determination, a preexisting condition exclusion denial determination, or the rescission of a policy or certificate.

(b) "Experimental treatment determination" means a determination by or on behalf of an insurer that issues a health benefit plan to which all of the following apply:

1. A proposed treatment has been reviewed.

2. Based on the information provided, the treatment under subd. 1. is determined to be experimental under the terms of the health benefit plan.

3. Based on the information provided, the insurer that issued the health benefit plan denied the treatment under subd. 1. or payment for the treatment under subd. 1.

4. Subject to sub. (5) (c), the cost or expected cost of the denied treatment or payment exceeds, or will exceed during the course of the treatment, $250.

(c) "Health benefit plan" has the meaning given in s. 632.745 (11), except that "health benefit plan" includes the coverage specified in s. 632.745 (11) (b) 10.

(cm) "Preexisting condition exclusion denial determination" means a determination by or on behalf of an insurer that issues a health benefit plan denying or terminating treatment or payment for treatment on the basis of a preexisting condition exclusion, as defined in s. 632.745 (23).

(d) "Treatment" means a medical service, diagnosis, procedure, therapy, drug or device.

(2) REVIEW REQUIREMENTS; WHO MAY CONDUCT. (a) Every insurer that issues a health benefit plan shall establish an independent review procedure whereby an insured under the health benefit plan, or his or her authorized representative, may request and

obtain an independent review of a coverage denial determination made with respect to the insured.

(b) If a coverage denial determination is made, the insurer involved in the determination shall provide notice to the insured of the insured's right to obtain the independent review required under this section, how to request the review, and the time within which the review must be requested. The notice shall include a current listing of independent review organizations certified under sub. (4). An independent review under this section may be conducted only by an independent review organization certified under sub. (4) and selected by the insured.

(bg) Notwithstanding par. (b), an insurer is not required to provide the notice under par. (b) to an insured until the insurer sends notice of the disposition of the internal grievance if all of the following apply:

1. The health benefit plan issued by the insurer contains a description of the independent review procedure under this section, including an explanation of the insured's rights under par. (d), how to request the review, the time within which the review must be requested, and how to obtain a current listing of independent review organizations certified under sub. (4).

2. The insurer includes on its explanation of benefits form a statement that the insured may have a right to an independent review after the internal grievance process and that an insured may be entitled to expedited independent review with respect to an urgent matter. The statement shall also include a reference to the section of the policy or certificate that contains the description of the independent review procedure as required under subd. 1. The statement shall provide a toll−free telephone number and website, if appropriate, where consumers may obtain additional information regarding internal grievance and independent review processes.

3. For any coverage denial determination for which an explanation of benefits is not provided to the insured, the insurer provides a notice that the insured may have a right to an independent review after the internal grievance process and that an insured may be entitled to expedited, independent review with respect to an urgent matter. The notice shall also include a reference to the section of the policy or certificate that contains the description of the independent review procedure as required under subd. 1. The notice shall provide a toll−free telephone number and website, if appropriate, where consumers may obtain additional information regarding internal grievance and independent review processes.

(c) Except as provided in par. (d), an insured must exhaust the internal grievance procedure under s. 632.83 before the insured may request an independent review under this section. Except as provided in sub. (9) (a), an insured who uses the internal grievance procedure must request an independent review as provided in sub. (3) (a) within 4 months after the insured receives notice of the disposition of his or her grievance under s. 632.83 (3) (d).

(d) An insured is not required to exhaust the internal grievance procedure under s. 632.83 before requesting an independent review if any of the following apply:

1. The insured and the insurer agree that the matter may proceed directly to independent review under sub. (3).

2. Along with the notice to the insurer of the request for independent review under sub. (3) (a), the insured submits to the independent review organization selected by the insured a request to bypass the internal grievance procedure under s. 632.83 and the independent review organization determines that the health condition of the insured is such that requiring the insured to use the internal grievance procedure before proceeding to independent review would jeopardize the life or health of the insured or the insured's ability to regain maximum function.

(e) Nothing in this section affects an insured's right to commence a civil proceeding relating to a coverage denial determination.

(3) PROCEDURE. (a) To request an independent review, an insured or his or her authorized representative shall provide timely written notice of the request for independent review, and of the independent review organization selected, to the insurer that made or on whose behalf was made the coverage denial determination. The insurer shall immediately notify the commissioner and the independent review organization selected by the insured of the request for independent review. For each independent review in which it is involved, an insurer shall pay a fee to the independent review organization.

(b) Within 5 business days after receiving written notice of a request for independent review under par. (a), the insurer shall submit to the independent review organization copies of all of the following:

1. Any information submitted to the insurer by the insured in support of the insured's position in the internal grievance under s. 632.83.

2. The contract provisions or evidence of coverage of the insured's health benefit plan.

3. Any other relevant documents or information used by the insurer in the internal grievance determination under s. 632.83.

(c) Within 5 business days after receiving the information under par. (b), the independent review organization shall request any additional information that it requires for the review from the insured or the insurer. Within 5 business days after receiving a request for additional information, the insured or the insurer shall submit the information or an explanation of why the information is not being submitted.

(d) An independent review under this section may not include appearances by the insured or his or her authorized representative, any person representing the health benefit plan or any witness on behalf of either the insured or the insurer.

(e) In addition to the information under pars. (b) and (c), the independent review organization may accept for consideration any typed or printed, verifiable medical or scientific evidence that the independent review organization determines is relevant, regardless of whether the evidence has been submitted for consideration at any time previously. The insurer and the insured shall submit to the other party to the independent review any information submitted to the independent review organization under this paragraph and pars. (b) and (c). If, on the basis of any additional information, the insurer reconsiders the insured's grievance and determines that the treatment that was the subject of the grievance should be covered, or that the policy or certificate that was rescinded should be reinstated, the independent review is terminated.

(f) 1. If the independent review is not terminated under par. (e), the independent review organization shall, within 30 business days after the expiration of all time limits that apply in the matter, make a decision on the basis of the documents and information submitted under this subsection. The decision shall be in writing, signed on behalf of the independent review organization and served by personal delivery or by mailing a copy to the insured or his or her authorized representative and to the insurer. Except as provided in subd. 2., a decision of an independent review organization is binding on the insured and the insurer.

2. A decision of an independent review organization regarding a preexisting condition exclusion denial determination or a rescission is not binding on the insured.

(g) If the independent review organization determines that the health condition of the insured is such that following the procedure outlined in pars. (b) to (f) would jeopardize the life or health of the insured or the insured's ability to regain maximum function, the procedure outlined in pars. (b) to (f) shall be followed with the following differences:

1. The insurer shall submit the information under par. (b) within one day after receiving the notice of the request for independent review under par. (a).

2. The independent review organization shall request any additional information under par. (c) within 2 business days after receiving the information under par. (b).

3. The insured or insurer shall, within 2 days after receiving a request under par. (c), submit any information requested or an explanation of why the information is not being submitted.

4. The independent review organization shall make its decision under par. (f) within 72 hours after the expiration of the time limits under this paragraph that apply in the matter.

(3m) STANDARDS FOR DECISIONS. (a) A decision of an independent review organization regarding an adverse determination or a preexisting condition exclusion denial determination must be consistent with the terms of the health benefit plan under which the adverse determination or preexisting condition exclusion denial determination was made.

(b) A decision of an independent review organization regarding an experimental treatment determination is limited to a determination of whether the proposed treatment is experimental. The independent review organization shall determine that the treatment is not experimental and find in favor of the insured only if the independent review organization finds all of the following:

1. The treatment has been approved by the federal food and drug administration, if the treatment is subject to the approval of the federal food and drug administration.

2. Medically and scientifically accepted evidence clearly demonstrates that the treatment meets all of the following criteria:

a. The treatment is proven safe.

b. The treatment can be expected to produce greater benefits than the standard treatment without posing a greater adverse risk to the insured.

c. The treatment meets the coverage terms of the health benefit plan and is not specifically excluded under the terms of the health benefit plan.

(4) CERTIFICATION OF INDEPENDENT REVIEW ORGANIZATIONS. (a) The commissioner shall certify independent review organizations. An independent review organization must demonstrate to the satisfaction of the commissioner that it is unbiased, as defined by the commissioner by rule. An organization certified under this paragraph must be recertified on a biennial basis to continue to provide independent review services under this section.

(ag) An independent review organization shall have in operation a quality assurance mechanism to ensure the timeliness and quality of the independent reviews, the qualifications and independence of the clinical peer reviewers and the confidentiality of the medical records and review materials.

(ap) An independent review organization shall establish reasonable fees that it will charge for independent reviews and shall submit its fee schedule to the commissioner for a determination of reasonableness and for approval. An independent review organization may not change any fees approved by the commissioner more than once per year and shall submit any proposed fee changes to the commissioner for approval.

(b) An organization applying for certification or recertification as an independent review organization shall pay the applicable fee under s. 601.31 (1) (Lp) or (Lr). Every organization certified or recertified as an independent review organization shall file a report with the commissioner in accordance with rules promulgated under sub. (5) (a) 4.

(c) The commissioner may examine, audit or accept an audit of the books and records of an independent review organization as provided for examination of licensees and permittees under s. 601.43 (1), (3), (4) and (5), to be conducted as provided in s. 601.44, and with costs to be paid as provided in s. 601.45.

(d) The commissioner may revoke, suspend or limit in whole or in part the certification of an independent review organization, or may refuse to recertify an independent review organization, if the commissioner finds that the independent review organization is unqualified or has violated an insurance statute or rule or a valid order of the commissioner under s. 601.41 (4), or if the independent review organization's methods or practices in the conduct of its business endanger, or its financial resources are inadequate to safeguard, the legitimate interests of consumers and the public. The commissioner may summarily suspend an independent review organization's certification under s. 227.51 (3).

(e) The commissioner shall keep an up–to–date listing of certified independent review organizations and shall provide a copy of the listing to all of the following:

1. Every insurer that is subject to this section, at least quarterly.

2. Any person who requests a copy of the listing.

(5) RULES; REPORT; ADJUSTMENTS. (a) The commissioner shall promulgate rules for the independent review required under this section. The rules shall include at least all of the following:

1. The application procedures for certification and recertification as an independent review organization.

2. The standards that the commissioner will use for certifying and recertifying organizations as independent review organizations, including standards for determining whether an independent review organization is unbiased.

3. Procedures and processes, in addition to those in sub. (3), that independent review organizations must follow.

4. What must be included in the report required under sub. (4) and the frequency with which the report must be filed with the commissioner.

5. Standards for the practices and conduct of independent review organizations.

6. Standards, in addition to those in sub. (6), addressing conflicts of interest by independent review organizations.

(b) The commissioner shall annually submit a report to the legislature under s. 13.172 (2) that specifies the number of independent reviews requested under this section in the preceding year, the insurers and health benefit plans involved in the independent reviews and the dispositions of the independent reviews.

(c) To reflect changes in the consumer price index for all urban consumers, U.S. city average, as determined by the U.S. department of labor, the commissioner shall at least annually adjust the amounts specified in sub. (1) (a) 4. and (b) 4.

(6) CONFLICT OF INTEREST STANDARDS. (a) An independent review organization may not be affiliated with any of the following:

1. A health benefit plan.

2. A national, state or local trade association of health benefit plans, or an affiliate of any such association.

3. A national, state or local trade association of health care providers, or an affiliate of any such association.

(b) An independent review organization appointed to conduct an independent review and a clinical peer reviewer assigned by an independent review organization to conduct an independent review may not have a material professional, familial or financial interest with any of the following:

1. The insurer that issued the health benefit plan that is the subject of the independent review.

2. Any officer, director or management employee of the insurer that issued the health benefit plan that is the subject of the independent review.

3. The health care provider that recommended or provided the health care service or treatment that is the subject of the independent review, or the health care provider's medical group or independent practice association.

4. The facility at which the health care service or treatment that is the subject of the independent review was or would be provided.

5. The developer or manufacturer of the principal procedure, equipment, drug or device that is the subject of the independent review.

6. The insured or his or her authorized representative.

(6m) QUALIFICATIONS OF CLINICAL PEER REVIEWERS. A clinical peer reviewer who conducts a review on behalf of a certified inde-

pendent review organization must satisfy all of the following requirements:

(a) Be a health care provider who is expert in treating the medical condition that is the subject of the review and who is knowledgeable about the treatment that is the subject of the review through current, actual clinical experience.

(b) Hold a credential, as defined in s. 440.01 (2) (a), that is not limited or restricted; or hold a license, certificate, registration or permit that authorizes or qualifies the health care provider to perform acts substantially the same as those acts authorized by a credential, as defined in s. 440.01 (2) (a), that was issued by a governmental authority in a jurisdiction outside this state and that is not limited or restricted.

(c) If a physician, hold a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the review.

(d) Have no history of disciplinary sanctions, including loss of staff privileges but excluding temporary suspension of staff privileges due to incomplete records, taken or pending by the medical examining board or another regulatory body or by any hospital or government.

(7) IMMUNITY. (a) A certified independent review organization is immune from any civil or criminal liability that may result because of an independent review determination made under this section. An employee, agent or contractor of a certified independent review organization is immune from civil liability and criminal prosecution for any act or omission done in good faith within the scope of his or her powers and duties under this section.

(b) A health benefit plan that is the subject of an independent review and the insurer that issued the health benefit plan shall not be liable to any person for damages attributable to the insurer's or plan's actions taken in compliance with any decision regarding an adverse determination or an experimental treatment determination rendered by a certified independent review organization.

(8) NOTICE OF SUFFICIENT INDEPENDENT REVIEW ORGANIZATIONS. (a) *Adverse and experimental treatment determinations.* The commissioner shall make a determination that at least one independent review organization has been certified under sub. (4) that is able to effectively provide the independent reviews required under this section for adverse determinations and experimental treatment determinations and shall publish a notice in the Wisconsin Administrative Register that states a date that is 2 months after the commissioner makes that determination. The date stated in the notice shall be the date on which the independent review procedure under this section begins operating with respect to adverse determinations and experimental treatment determinations.

(b) *Preexisting condition exclusion denials and rescissions.* The commissioner shall make a determination that at least one independent review organization has been certified under sub. (4) that is able to effectively provide the independent reviews required under this section for preexisting condition exclusion denial determinations and rescissions and shall publish a notice in the Wisconsin Administrative Register that states a date that is 2 months after the commissioner makes that determination. The date stated in the notice shall be the date on which the independent review procedure under this section begins operating with respect to preexisting condition exclusion denial determinations and rescissions.

(9) APPLICABILITY. (a) *Adverse and experimental treatment determinations.* The independent review required under this section with respect to an adverse determination or an experimental treatment determination shall be available to an insured who receives notice of the disposition of his or her grievance under s. 632.83 (3) (d) on or after December 1, 2000. Notwithstanding sub. (2) (c), an insured who receives notice of the disposition of his or her grievance under s. 632.83 (3) (d) on or after December 1, 2000, but before June 15, 2002, with respect to an adverse determination or an experimental treatment determination must request an independent review no later than 4 months after June 15, 2002.

(b) *Preexisting condition exclusion denials and rescissions.* The independent review required under this section with respect to a preexisting condition exclusion denial determination or a rescission shall be available to an insured who receives notice of the disposition of his or her grievance under s. 632.83 (3) (d) on or after the date stated in the notice published in the Wisconsin Administrative Register by the commissioner under sub. (8) (b).

History: 1999 a. 155; 2001 a. 65; 2009 a. 28, 276; 2017 a. 365 s. 112.

Cross–reference: See also ch. Ins 18, Wis. adm. code.

632.84 Benefit appeals under certain policies. (1) DEFINITIONS. In this section:

(a) "Nursing home" has the meaning given in s. 50.01 (3).

(b) "Nursing home insurance policy" means an individual or group insurance policy which provides coverage primarily for confinement or care in a nursing home.

(2) REVIEW AND APPEAL. (a) Except as provided in sub. (3), an insurer offering a medicare supplement policy, medicare replacement policy, nursing home insurance policy or long–term care insurance policy shall establish an internal procedure by which the policyholder or the certificate holder or a representative of the policyholder or the certificate holder may appeal the denial of any benefits under the medicare supplement policy, medicare replacement policy, nursing home insurance policy or long–term care insurance policy. The procedure established under this paragraph shall include all of the following:

1. The opportunity for the policyholder or certificate holder or a representative of the policyholder or certificate holder to submit a written request, which may be in any form and which may include supporting material, for review by the insurer of the denial of any benefits under the policy.

2. Within 30 days after receiving the request under subd. 1., disposition of the review and notification to the person submitting the request of the results of the review.

(b) An insurer shall describe the procedure established under par. (a) in every policy, group certificate and outline of coverage issued in connection with a medicare supplement policy, medicare replacement policy, nursing home insurance policy or long–term care insurance policy.

(c) If an insurer denies any benefits under a medicare supplement policy, medicare replacement policy, nursing home insurance policy or long–term care insurance policy, the insurer shall, at the time the insurer gives notice of the denial of any benefits, provide the policyholder and certificate holder with a written description of the appeal process established under par. (a).

(d) An insurer offering a medicare supplement policy, medicare replacement policy, nursing home insurance policy or long–term care insurance policy shall annually report to the commissioner a summary of all appeals filed under this section and the disposition of those appeals.

(3) EXCEPTIONS. This section does not apply to a health maintenance organization, limited service health organization or preferred provider plan, as defined in s. 609.01.

History: 1987 a. 156, 403; 1989 a. 31.

Cross–reference: See also s. Ins 3.55, Wis. adm. code.

632.845 Prohibiting refusal to cover services because liability policy may cover. (1) In this section, "health care plan" has the meaning given in s. 628.36 (2) (a) 1.

(2) An insurer that provides coverage under a health care plan may not refuse to cover health care services that are provided to an insured under the plan and for which there is coverage under the plan on the basis that there may be coverage for the services under a liability insurance policy.

History: 2009 a. 28.

632.85 Coverage without prior authorization for treatment of an emergency medical condition. (1) In this section:

(a) "Emergency medical condition" means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a prudent layperson who possesses an average knowledge of health and medicine to reasonably conclude that a lack of immediate medical attention will likely result in any of the following:

1. Serious jeopardy to the person's health or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child.

2. Serious impairment to the person's bodily functions.

3. Serious dysfunction of one or more of the person's body organs or parts.

(b) "Health care plan" has the meaning given in s. 628.36 (2) (a) 1.

(c) "Self–insured health plan" means a self–insured health plan of the state or a county, city, village, town or school district.

(2) If a health care plan or a self–insured health plan provides coverage of any emergency medical services, the health care plan or self–insured health plan shall provide coverage of emergency medical services that are provided in a hospital emergency facility and that are needed to evaluate or stabilize, as defined in section 1867 of the federal Social Security Act, an emergency medical condition.

(3) A health care plan or a self–insured health plan that is required to provide the coverage under sub. (2) may not require prior authorization for the provision or coverage of the emergency medical services specified in sub. (2).

History: 1997 a. 155.

632.853 Coverage of drugs and devices. A health care plan, as defined in s. 628.36 (2) (a) 1., or a self–insured health plan, as defined in s. 632.85 (1) (c), that provides coverage of only certain specified prescription drugs or devices shall develop a process through which a physician may present medical evidence to obtain an individual patient exception for coverage of a prescription drug or device not routinely covered by the plan. The process shall include timelines for both urgent and nonurgent review.

History: 1997 a. 237.

632.855 Requirements if experimental treatment limited. (1) DEFINITIONS. In this section:

(a) "Health care plan" has the meaning given in s. 628.36 (2) (a) 1.

(b) "Self–insured health plan" has the meaning given in s. 632.85 (1) (c).

(2) DISCLOSURE OF LIMITATIONS. Subject to s. 632.87 (6), a health care plan or a self–insured health plan that limits coverage of experimental treatment shall define the limitation and disclose the limits in any agreement, policy or certificate of coverage. This disclosure shall include the following information:

(a) Who is authorized to make a determination on the limitation.

(b) The criteria the plan uses to determine whether a treatment, procedure, drug or device is experimental.

(3) DENIAL OF TREATMENT. (am) A health care plan or a self–insured health plan that receives a request for prior authorization of an experimental procedure that includes all of the required information upon which to make a decision shall, within 5 working days after receiving the request, issue a coverage decision. If the health care plan or self–insured health plan denies coverage of an experimental treatment, procedure, drug or device for an insured who has a terminal condition or illness, the health care plan or self–insured health plan shall, as part of its coverage decision, provide the insured with a denial letter that includes all of the following:

1. A statement setting forth the specific medical and scientific reasons for denying coverage.

2. Notice of the insured's right to appeal and a description of the appeal procedure.

(bm) A health care plan or a self–insured health plan may not deny coverage under par. (am) of an experimental treatment, procedure, drug, or device for an insured if the denial violates s. 632.87 (6).

History: 1997 a. 237; 2005 a. 194.

632.857 Explanation required for restriction or termination of coverage. If an insurer restricts or terminates an insured's coverage for the treatment of a condition or complaint and, as a result, the insured becomes liable for payment for all of his or her treatment for the condition or complaint, the insurer shall provide on the explanation of benefits form a detailed explanation of the clinical rationale and of the basis in the policy, plan, or contract or in applicable law for the insurer's restriction or termination of coverage.

History: 2007 a. 20.

632.86 Restrictions on pharmaceutical services. (1) In this section:

(a) "Disability insurance policy" has the meaning given in s. 632.895 (1) (a), except that the term does not include coverage under a health maintenance organization, as defined in s. 609.01 (2), a limited service health organization, as defined in s. 609.01 (3), a preferred provider plan, as defined in s. 609.01 (4), or a health care plan operated by a cooperative association organized under s. 185.981.

(b) "Pharmaceutical mail order plan" means a plan under which prescribed drugs or devices are dispensed through the mail.

(c) "Prescribed drug or device" has the meaning given in s. 450.01 (18).

(2) No group or blanket disability insurance policy that provides coverage of prescribed drugs or devices through a pharmaceutical mail order plan may do any of the following:

(a) Exclude coverage, expressly or by implication, of any prescribed drug or device provided by a pharmacist or pharmacy selected by a covered individual if the pharmacist or pharmacy provides or agrees to provide prescribed drugs or devices under the terms of the policy and at the same cost to the insurer issuing the policy as a pharmaceutical mail order plan.

(b) Contain coverage, deductible or copayment provisions for prescribed drugs or devices provided by a pharmacist or pharmacy selected by a covered individual that are different from the coverage, deductible or copayment provisions for prescribed drugs or devices provided by a pharmaceutical mail order plan.

History: 1991 a. 70; 2009 a. 165.

632.865 Pharmacy benefit managers. (1) DEFINITIONS. In this section:

(a) "Pharmacist" has the meaning given in s. 450.01 (15).

(b) "Pharmacy" means an entity licensed under s. 450.06 or 450.065.

(c) "Pharmacy benefit manager" means an entity doing business in this state that contracts to administer or manage prescription drug benefits on behalf of any insurer or other entity that provides prescription drug benefits to residents of this state.

(d) "Prescribed drug or device" has the meaning given in s. 450.01 (18).

(e) "Prescription drug benefit" means coverage of or payment or assistance for prescribed drugs or devices.

(2) PRICING TRANSPARENCY. (a) The pharmacy benefit manager shall agree in each contract or renewal to do all of the following:

1. Update maximum allowable cost pricing information for prescribed drugs or devices at least every 7 business days and provide a means by which contracted pharmacies may promptly

review pricing updates in a format that is readily available and accessible.

2. Reimburse pharmacists and pharmacies for prescribed drugs or devices subject to maximum allowable cost information that has been updated at least every 7 business days.

3. Eliminate prescribed drugs or devices from the maximum allowable cost information or modify maximum allowable cost in a timely fashion consistent with availability of prescribed drugs or devices and pricing changes in the marketplace.

(b) A pharmacy benefit manger shall include in each contract with a pharmacy a process to appeal, investigate, and resolve disputes regarding maximum allowable cost pricing that includes all of the following:

1. A 21–day limit on the right to appeal following the initial claim.

2. A requirement that the appeal be investigated and resolved within 21 days after the date of the appeal.

3. A dedicated telephone number at which the pharmacy may contact the pharmacy benefit manager to speak to a person responsible for processing appeals.

4. A requirement that a pharmacy benefit manager provide a reason for any appeal denial and the national drug code published in a directory by the federal food and drug administration of a prescribed drug or device that may be purchased by retail network pharmacies at a price at or below the maximum allowable cost.

5. A requirement that a pharmacy benefit manager make a pricing adjustment no later than one day after the date of the final determination of the appeal.

History: 2015 a. 55.

632.866 Step therapy protocols. (1) DEFINITIONS. In this section:

(a) "Clinical practice guideline" means a systematically developed statement to assist decision making by health care providers and patients about appropriate health care for specific clinical circumstances and conditions.

(b) "Clinical review criteria" means written screening procedures, decision abstracts, clinical protocols, and clinical practice guidelines used by an insurer, pharmacy benefit manager, or utilization review organization to determine whether health care services are medically necessary and appropriate.

(c) "Exigent circumstances" means when a patient is suffering from a health condition that may seriously jeopardize the patient's life, health, or ability to regain maximum function.

(d) "Pharmacy benefit manager" has the meaning given in s. 632.865 (1) (c).

(e) "Step therapy protocol" means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition, whether self–administered or physician–administered, that are medically appropriate for a particular patient are covered under a policy or plan.

(f) "Utilization review organization" means an entity that conducts utilization review, other than an insurer or pharmacy benefit manager performing utilization review for its own policy or plan.

(2) CLINICAL REVIEW CRITERIA. (a) When establishing a step therapy protocol, an insurer, pharmacy benefit manager, or utilization review organization shall use clinical review criteria that are based on clinical practice guidelines that are derived from peer–review publications, evidence–based research, and widely accepted medical practice. If such clinical practice guidelines are unavailable, the insurer, pharmacy benefit manager, or utilization review organization shall derive clinical review criteria from peer–reviewed publications, evidence–based research, and widely accepted medical practice. The insurer, pharmacy benefit manager, or utilization review organization shall continually update the clinical review criteria based on an update to the clinical practice guidelines or a review of new evidence and research and newly developed treatments.

(b) Any individual involved in establishing a step therapy protocol under this subsection shall disclose to the insurer, pharmacy benefit manager, or utilization review organization any potential conflict of interest due to a financial or other relationship or payment from a pharmaceutical manufacturer and shall recuse himself or herself from voting on a decision regarding the step therapy protocol if he or she has a conflict of interest.

(c) An insurer, pharmacy benefit manager, or utilization review organization shall describe on its Internet site the process and criteria used for selecting and evaluating clinical practice guidelines used under par. (a) to develop step therapy protocols.

(d) Nothing in this subsection shall be construed to require insurers, pharmacy benefit managers, or the state to create a new entity to develop clinical review criteria used for step therapy protocols.

(3) TRANSPARENCY OF EXCEPTIONS PROCESS. (a) When coverage of a prescription drug for the treatment of any medical condition is restricted for use by an insurer, pharmacy benefit manager, or utilization review organization through the use of a step therapy protocol, the insurer, pharmacy benefit manager, or utilization review organization shall provide access to a clear, readily accessible, and convenient process to request an exception to the step therapy protocol. An insurer, pharmacy benefit manager, or utilization review organization may use any existing medical exceptions process to satisfy the requirement under this paragraph. The exception process shall be made easily accessible on the Internet site of the insurer, pharmacy benefit manager, or utilization review organization.

(b) An insurer, pharmacy benefit manager, or utilization review organization shall grant an exception to the step therapy protocol if the prescribing provider submits complete, clinically relevant written documentation supporting a step therapy exception request and any of the following are satisfied:

1. The prescription drug required under the step therapy protocol is contraindicated or, due to a documented adverse event with a previous use or a documented medical condition, including a comorbid condition, is likely to do any of the following:

a. Cause a serious adverse reaction in the patient.

b. Decrease the ability to achieve or maintain reasonable functional ability in performing daily activities.

c. Cause physical or psychiatric harm to the patient.

2. The prescription drug required under the step therapy protocol is expected to be ineffective based on all of the following:

a. Sound clinical evidence or medical and scientific evidence.

b. The known clinical characteristics of the patient.

c. The known characteristics of the prescription drug regimen as described in peer–reviewed literature or the manufacturer's prescribing information for the prescription drug.

3. The patient has tried the prescription drug required under the step therapy protocol, or another prescription drug in the same pharmacologic class or with the same mechanism of action, under the policy or plan or a previous policy or plan, the patient was adherent to the prescription drug regimen for a time that allows for a positive treatment outcome, and the patient's use of the prescription drug was discontinued by the patient's provider due to lack of efficacy or effectiveness, diminished effect, or adverse event. This subdivision does not prohibit an insurer, pharmacy benefit manager, or utilization review organization from requiring a patient to try another drug in the same pharmacologic class or with the same mechanism of action if that therapy sequence is supported by clinical review criteria under sub. (2) (a).

4. The patient is stable on a prescription drug selected by his or her health care provider for the medical condition under consideration while covered under the policy or plan or a previous policy or plan.

(c) Nothing in this subsection shall be construed to allow the use of a pharmaceutical sample to satisfy a criterion for an exception to a step therapy protocol.

(d) Upon granting an exception to the step therapy protocol under par. (b), the insurer, pharmacy benefit manager, or utilization review organization shall authorize coverage for the prescription drug prescribed by the patient's treating health care provider to the extent the prescribed drug is covered under the patient's policy or plan.

(e) An insured may appeal any request for an exception to the step therapy protocol that is denied.

(f) An insurer, pharmacy benefit manager, or utilization review organization shall grant or deny a request for any exception to the step therapy protocol within 3 business days of receipt of the complete, clinically relevant written documentation required under par. (b) to support a step therapy exception request under par. (b) or the receipt of a request to appeal a previous decision that includes the complete, clinically relevant written documentation supporting a step therapy exception request. In exigent circumstances, an insurer, pharmacy benefit manager, or utilization review organization shall grant or deny a request for an exception to the step therapy protocol by the end of the next business day after receipt of the complete, clinically relevant written documentation supporting a step therapy exception request under par. (b). If the insurer, pharmacy benefit manager, or utilization review organization does not grant or deny a request or an appeal under the time specified under this paragraph, the exception is considered granted.

(g) Nothing in this subsection shall be construed to prevent any of the following:

1. An insurer, pharmacy benefit manager, or utilization review organization from requiring a patient to try an A–rated generic equivalent prescription drug, as designated by the federal food and drug administration, or a biosimilar, as defined under 42 USC 262 (i) (2), before providing coverage for the equivalent brand name prescription drug.

2. A health care provider from prescribing a prescription drug that is determined to be medically appropriate.

(4) RULES. The commissioner shall promulgate any rules necessary to implement or enforce this section.

History: 2019 a. 12; s. 35.17 correction in (3) (a).

632.867 Oral and injected chemotherapy. (1) DEFINITIONS. In this section:

(a) "Chemotherapy" means drugs and biologics that kill cancer cells directly, including antineoplastics, biologic response modifiers, hormone therapy, and monoclonal antibodies, and that are used to do any of the following:

1. Cure a specific cancer.

2. Control tumor growth when cure is not possible.

3. Shrink tumors before surgery or radiation therapy.

4. Destroy microscopic cancer cells that may be present after a tumor is removed by surgery to prevent a cancer recurrence.

(b) "Disability insurance policy" has the meaning given in s. 632.895 (1) (a).

(c) "Self–insured health plan" has the meaning given in s. 632.85 (1) (c).

(2) COPAYMENT, DEDUCTIBLE, OR COINSURANCE REQUIREMENTS; LIMITATIONS. (a) Except as provided in par. (am), a disability insurance policy that covers injected or intravenous chemotherapy and oral chemotherapy, or a self–insured health plan that covers injected or intravenous chemotherapy and oral chemotherapy, may not require a higher copayment, deductible, or coinsurance amount for oral chemotherapy than it requires for injected or intravenous chemotherapy, regardless of the formulation or benefit category determination by the policy or plan.

(am) A disability insurance policy or self–insured health plan that limits copayments paid by a covered individual to no more than $100 for a 30–day supply of oral chemotherapy medication is considered to comply with this section. On January 1, 2016, and on each January 1 annually thereafter, a disability insurance policy or self–insured health plan may adjust the $100 limit under this paragraph by an amount that does not exceed the percentage increase in the U.S. consumer price index for all urban consumers, U.S. city average, as determined by the U.S. department of labor.

(b) A disability insurance policy or a self–insured health plan may not comply with par. (a) by increasing the copayment, deductible, or coinsurance amount required for injected or intravenous chemotherapy that is covered under the policy or plan.

(c) Notwithstanding par. (a), for a disability insurance policy, or self–insured health plan, that is a high deductible health plan, as defined in 26 USC 223 (c) (2), par. (a) applies only after the plan enrollee's deductible has been satisfied for the year.

History: 2013 a. 186.

632.87 Restrictions on health care services. (1) No insurer may refuse to provide or pay for benefits for health care services provided by a licensed health care professional on the ground that the services were not rendered by a physician as defined in s. 990.01 (28), unless the contract clearly excludes services by such practitioners, but no contract or plan may exclude services in violation of sub. (2), (2m), (3), (4), (4m), (5), or (6).

(2) No insurer may, under a contract or plan covering vision care services or procedures, refuse to provide coverage for vision care services or procedures provided by an optometrist licensed under ch. 449 within the scope of the practice of optometry, as defined in s. 449.01 (1), if the contract or plan includes coverage for the same services or procedures when provided by another health care provider.

(2m) No health maintenance organization or preferred provider plan that provides vision care services or procedures within the scope of the practice of optometry, as defined in s. 449.01 (1), may do any of the following:

(am) Fail to provide to persons covered by the health maintenance organization or preferred provider plan, at the time of enrollment and annually thereafter, a listing of then participating vision care providers, including participating optometrists, setting forth the names of the vision care providers in alphabetical order by last name and their respective business addresses and telephone numbers, with the listing of participating vision care providers to be incorporated in any listing of all participating health care providers that includes the same information regarding all providers, if such listing is provided at the time of enrollment and annually thereafter, or with the listing of participating vision care providers otherwise to be provided separately.

(b) Fail to provide to persons covered by the health maintenance organization or preferred provider plan, at the time vision care services or procedures are needed, the opportunity to choose optometrists from the listing under par. (am) from whom the persons may obtain covered vision care services and procedures within the scope of the practice of optometry, as defined in s. 449.01 (1).

(c) Fail to include as participating providers in the health maintenance organization or preferred provider plan optometrists licensed under ch. 449 in sufficient numbers to meet the demand of persons covered by the health maintenance organization or preferred provider plan for optometric services.

(d) When vision care services or procedures are deemed appropriate by the health maintenance organization or preferred provider plan, restrict or discourage a person covered by the health maintenance organization or preferred provider plan from obtaining covered vision care services or procedures, within the scope of the practice of optometry as defined in s. 449.01 (1), from participating optometrists solely on the basis that the providers are optometrists.

(3) (a) No policy, plan or contract may exclude coverage for diagnosis and treatment of a condition or complaint by a licensed chiropractor within the scope of the chiropractor's professional license, if the policy, plan or contract covers diagnosis and treat-

ment of the condition or complaint by a licensed physician or osteopath, even if different nomenclature is used to describe the condition or complaint. Examination by or referral from a physician shall not be a condition precedent for receipt of chiropractic care under this paragraph. This paragraph does not:

1. Prohibit the application of deductibles or coinsurance provisions to chiropractic and physician charges on an equal basis.

2. Prohibit the application of cost containment or quality assurance measures to chiropractic services in a manner that is consistent with cost containment or quality assurance measures generally applicable to physician services and that is consistent with this section.

(b) No insurer, under a policy, plan or contract covering diagnosis and treatment of a condition or complaint by a licensed chiropractor within the scope of the chiropractor's professional license, may do any of the following:

1. Restrict or terminate coverage for the treatment of a condition or a complaint by a licensed chiropractor within the scope of the chiropractor's professional license on the basis of other than an examination or evaluation by or a recommendation of a licensed chiropractor or a peer review committee that includes a licensed chiropractor.

2. Refuse to provide coverage to an individual because that individual has been treated by a chiropractor.

3. Establish underwriting standards that are more restrictive for chiropractic care than for care provided by other health care providers.

4. Exclude or restrict health care coverage of a health condition solely because the condition may be treated by a chiropractor.

(c) An exclusion or a restriction that violates par. (b) is void in its entirety.

(4) No policy, plan or contract may exclude coverage for diagnosis and treatment of a condition or complaint by a licensed dentist within the scope of the dentist's license, if the policy, plan or contract covers diagnosis and treatment of the condition or complaint by another health care provider, as defined in s. 146.81 (1) (a) to (p).

(4m) No policy, plan, or contract may exclude coverage for mental health or behavioral health treatment or services provided by the charter school established under a contract under s. 118.40 (2x) (cm), if the policy, plan, or contract covers the mental health or behavioral health treatment or services when provided by another health care provider, as defined in s. 146.81 (1) (a) to (p). The operator of the charter school established under a contract under s. 118.40 (2x) (cm) shall, upon the enrollment of a pupil in the charter school, notify the policy, plan, or contract that covers the pupil's mental health or behavioral health treatment or services of the services that the policy, plan, or contract may be required to cover under this subsection. If requested by a policy, plan, or contract, an operator of the charter school established under a contract under s. 118.40 (2x) (cm) shall enter into a memorandum of understanding with a policy, plan, or contract on matters other than the coverage required under this subsection, including reimbursement, payment terms, and compliance with state and federal patient health information privacy laws.

(5) No insurer or self–insured school district, city or village may, under a policy, plan or contract covering gynecological services or procedures, exclude or refuse to provide coverage for Papanicolaou tests, pelvic examinations or associated laboratory fees when the test or examination is performed by a licensed nurse practitioner, as defined in s. 632.895 (8) (a) 3., within the scope of the nurse practitioner's professional license, if the policy, plan or contract includes coverage for Papanicolaou tests, pelvic examinations or associated laboratory fees when the test or examination is performed by a physician.

(6) (a) 1. Except as provided in subd. 2., in this subsection, "routine patient care" means all of the following:

a. All health care services, items, and drugs for the treatment of cancer.

b. All health care services, items, and drugs that are typically provided in health care; including health care services, items, and drugs provided to a patient during the course of treatment in a cancer clinical trial for a condition or any of its complications; and that are consistent with the usual and customary standard of care, including the type and frequency of any diagnostic modality.

2. "Routine patient care" does not include the health care service, item, or investigational drug that is the subject of the cancer clinical trial; any health care service, item, or drug provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient; an investigational drug or device that has not been approved for market by the federal food and drug administration; transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that are associated with travel to or from a facility providing the cancer clinical trial; any services, items, or drugs provided by the cancer clinical trial sponsors free of charge for any patient; or any services, items, or drugs that are eligible for reimbursement by a person other than the insurer, including the sponsor of the cancer clinical trial.

(b) No policy, plan, or contract may exclude coverage for the cost of any routine patient care that is administered to an insured in a cancer clinical trial satisfying the criteria under par. (c) and that would be covered under the policy, plan, or contract if the insured were not enrolled in a cancer clinical trial.

(c) A cancer clinical trial under par. (b) must satisfy all of the following criteria:

1. A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes.

2. The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes.

3. The trial has therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.

4. The trial does one of the following:

a. Tests how to administer a health care service, item, or drug for the treatment of cancer.

b. Tests responses to a health care service, item, or drug for the treatment of cancer.

c. Compares the effectiveness of health care services, items, or drugs for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer.

d. Studies new uses of health care services, items, or drugs for the treatment of cancer.

5. The trial is approved by one of the following:

a. A National Institute of Health, or one of its cooperative groups or centers, under the federal department of health and human services.

b. The federal food and drug administration.

c. The federal department of defense.

d. The federal department of veterans affairs.

(d) 1. The coverage that may not be excluded under this subsection shall apply to all phases of a cancer clinical trial.

2. The coverage that may not be excluded under this subsection is subject to all terms, conditions, restrictions, exclusions, and limitations that apply to any other coverage under the policy, plan, or contract, including the treatment under the policy, plan, or contract of services performed by participating and nonparticipating providers.

(e) 1. Nothing in the subsection requires a policy, plan, or contract to offer; or prohibits a policy, plan, or contract from offering; cancer clinical trial services by a participating provider.

2. Nothing in this subsection requires services that are performed in a cancer clinical trial by a nonparticipating provider of

a policy, plan, or contract to be reimbursed at the same rate as a participating provider of the policy, plan, or contract.

History: 1975 c. 223, 371, 422; 1981 c. 205; 1983 a. 27; 1985 a. 29; 1987 a. 27; 1991 a. 39, 269; 1995 a. 412; 2005 a. 194; 2009 a. 28; 2017 a. 30, 366.

Legislative Council Note, 1975: This [sub. (1)] continues (and expands the scope of) s. 207.04 (1) (k) [repealed by this act], which does not deal with an unfair marketing practice but an unduly restrictive interpretation of an insurance contract. Presently it applies only to podiatrists but the same principles apply to all health care professionals. Since the legislature has licensed podiatrists (s. 448.10 et. seq.), as well as other health care professionals who are not physicians, applicable insurance contracts should provide benefits for their services or payment to them, as well as for those of physicians, unless they are specifically and clearly excluded by a policy which has been approved by the commissioner. But general principles of freedom of contract should be operative if the contract is clear enough. Parties negotiating for insurance coverage should be free to decide what kind of health care services they want and are willing to pay for. [Bill 16–S]

632.873 Restrictions relating to fees for dental services. (1) DEFINITIONS. In this section, unless the context requires otherwise:

(a) "Covered service" means, with respect to dental or related services specified in a policy or plan that provides coverage for those services, a service provided by a dentist or at the direction of a dentist to an insured under the policy or an enrollee of the plan for which the policy or plan makes payment, administered consistently with policies traditionally governing covered services, or for which the policy or plan would make payment but for the application of contractual limitations of deductibles, copayments, coinsurance, waiting periods, annual maximums, lifetime maximums applicable to the same course of treatment, frequency limitations, or alternative benefit payments.

(b) "Policy" means a policy, certificate, or contract of insurance that provides only limited–scope dental benefits.

(c) "Related service" means a service that is commonly provided, by a dentist or at the direction of a dentist, in conjunction with a dental service.

(2) PROHIBITIONS ON SETTING FEES. (a) 1. A contract between an insurer offering a policy that provides coverage for dental and related services and a dentist for the provision of dental and related services to an insured under the policy may not require the dentist to provide a service to an insured under the policy at a fee set by the insurer unless the service is a covered service under the policy.

2. A policy that provides coverage for dental and related services may not provide nominal or de minimis coverage for a dental or related service for the sole purpose of avoiding the requirements under subd. 1.

(b) An administrator providing 3rd–party administration services or a provider network for a plan that provides coverage for dental and related services may not require any dentist in the administrator's provider network that is eligible to provide services under the plan to charge set fees for dental or related services provided to enrollees of the plan that are not covered services under the plan.

(3) PROHIBITION ON CHARGES. A dentist who, under a contract with an insurer offering a policy that provides coverage for dental and related services, provides dental or related services to an insured under the policy may not charge the insured more than the dentist's usual nondiscounted fee for a dental or related service that is not a covered service under the policy.

History: 2013 a. 26.

632.875 Independent evaluations relating to chiropractic treatment. (1) In this section:

(a) "Chiropractor" means a person licensed to practice chiropractic under ch. 446.

(b) "Independent evaluation" means an examination or evaluation by or recommendation of a chiropractor or a peer review committee under s. 632.87 (3) (b) 1.

(c) "Patient" means a person whose treatment by a chiropractor is the subject of an independent evaluation.

(d) "Treating chiropractor" means a chiropractor who is treating a patient and whose treatment of the patient is the subject of an independent evaluation.

(2) If, on the basis of an independent evaluation, an insurer restricts or terminates a patient's coverage for the treatment of a condition or complaint by a chiropractor acting within the scope of his or her license and the restriction or termination of coverage results in the patient becoming liable for payment for his or her treatment, the insurer shall, within the time required under s. 628.46 (2m), provide to the patient and to the treating chiropractor a written statement that contains all of the following:

(a) A statement that an independent evaluation has been conducted under s. 632.87 (3) (b) 1.

(b) The name of the treating chiropractor.

(c) The name of the patient.

(d) A description of the insurer's internal appeal process that is available to the patient.

(e) A statement indicating that the patient may, no later than 30 days after receiving the statement required under this subsection, request an internal appeal of the insurer's restriction or termination of coverage.

(f) The address to which the patient should send the request for an appeal.

(g) A detailed explanation of the clinical rationale and of the basis in the policy, plan, or contract or in applicable law for the insurer's restriction or termination of coverage.

(h) A list of records and documents reviewed as part of the independent evaluation.

(3) (a) In this subsection, "claim" means a patient's claim for coverage, under a policy, plan or contract covering diagnosis and treatment of a condition or complaint by a licensed chiropractor within the scope of the chiropractor's professional license, the restriction or termination of which coverage is the subject of an independent evaluation.

(b) A chiropractor who conducts an independent evaluation may not be compensated by an insurer based on a percentage of the dollar amount by which a claim is reduced as a result of the independent evaluation.

(4) Subject to sub. (2) (e), an insurer shall make available to a patient an internal procedure by which the patient may appeal an insurer's decision to restrict or terminate coverage.

(5) This section does not apply to any of the following:

(a) Worker's compensation insurance.

(b) Any line of property and casualty insurance except disability insurance. In this paragraph, "disability insurance" does not include uninsured motorist coverage, underinsured motorist coverage or medical payment coverage.

History: 1995 a. 94; 2001 a. 16; 2007 a. 20.

632.88 Policy extension for handicapped children. (1) TERMINATION OF COVERAGE. Every hospital or medical expense insurance policy or contract that provides that coverage of a dependent child of a person insured under the policy shall terminate upon attainment of a limiting age for dependent children specified in the policy shall also provide that the age limitation may not operate to terminate the coverage of a dependent child while the child is and continues to be both:

(a) Incapable of self–sustaining employment because of intellectual disability or physical handicap; and

(b) Chiefly dependent upon the person insured under the policy for support and maintenance.

(2) PROOF OF INCAPACITY. The insurer may require that proof of the incapacity and dependency be furnished by the person insured under the policy within 31 days of the date the child attains the limiting age, and at any time thereafter except that the insurer may not require proof more frequently than annually after the 2–year period immediately following attainment of the limiting age by the child.

History: 1975 c. 375; 2011 a. 126.

632.885 Coverage of dependents. (1) DEFINITIONS. In this section:

(af) "Eligible employer–sponsored plan" has the meaning given in 26 USC 5000A (f) (2).

(ar) "Grandfathered health plan" has the meaning given under section 1251 of the Patient Protection and Affordable Care Act (P.L. 111–148).

(at) "Health insurance coverage" has the meaning given in 42 USC 300gg–91 (b) (1).

(b) "Insured" includes an enrollee.

(c) "Self–insured health plan" has the meaning given in s. 632.745 (24).

(2) REQUIREMENT TO OFFER DEPENDENT COVERAGE. (a) Subject to ss. 632.88 and 632.895 (5), and except as provided in pars. (b) and (c), every insurer that offers health insurance coverage that provides dependent coverage of children, and every self–insured health plan that provides dependent coverage of children, shall provide coverage for any child of an applicant or insured as a dependent of the applicant or insured if the child is under the age of 26.

(b) Except as provided in par. (c), the coverage requirement under this section applies to an adult child who satisfies all of the following criteria:

1. The child is a full–time student, regardless of age.

3. The child was called to federal active duty in the national guard or in a reserve component of the U.S. armed forces while the child was attending, on a full–time basis, an institution of higher education.

4. The child was under the age of 27 years when called to federal active duty under subd. 3.

(c) For any policy year or plan year beginning before January 1, 2014, health insurance coverage or a self–insured health plan described in par. (a) that is a grandfathered health plan is required to provide dependent coverage for an adult child described in par. (a) or (b) only if the child is not eligible for coverage under an eligible employer–sponsored plan other than the health insurance coverage or self–insured health plan.

(3m) DEFINING DEPENDENT; UNIFORM TERMS. An insurer or self–insured health plan described in sub. (2) may not do any of the following:

(a) Define "dependent" for purposes of eligibility for dependent coverage of children other than in terms of the relationship between a child and an applicant or insured.

(b) Vary the terms of coverage under the health insurance coverage or self–insured health plan on the basis of age except for children 26 years of age or older.

History: 2009 a. 28; 2011 a. 32.

Cross–reference: See also s. Ins 3.34, Wis. adm. code.

632.89 Coverage of mental disorders, alcoholism, and other diseases. (1) DEFINITIONS. In this section:

(a) "Collateral" means a member of an insured's immediate family, as defined in s. 632.895 (1).

(at) "Group health benefit plan" has the meaning given in s. 632.745 (9).

(b) "Health benefit plan" has the meaning given in s. 632.745 (11).

(c) "Hospital" means any of the following:

1. A hospital licensed under s. 50.35.

2. An approved private treatment facility as defined in s. 51.45 (2) (b).

3. An approved public treatment facility as defined in s. 51.45 (2) (c).

(d) "Inpatient hospital services" means services for the treatment of nervous and mental disorders or alcoholism and other drug abuse problems that are provided in a hospital to a bed patient in the hospital.

(dm) "Licensed mental health professional" means a clinical social worker who is licensed under ch. 457, a marriage and family therapist who is licensed under s. 457.10, or a professional counselor who is licensed under s. 457.12.

(e) "Outpatient services" means nonresidential services for the treatment of nervous or mental disorders or alcoholism or other drug abuse problems provided to an insured and, if for the purpose of enhancing the treatment of the insured, a collateral by any of the following:

1. A program in an outpatient treatment facility, if both are approved by the department of health services, the program is established and maintained according to rules promulgated under s. 51.42 (7) (b) and the facility is certified under s. 51.04.

2. A licensed physician who has completed a residency in psychiatry, in an outpatient treatment facility or the physician's office.

3. A psychologist licensed under ch. 455.

4. A licensed mental health professional practicing within the scope of his or her license under ch. 457 and applicable rules.

(em) "Self–insured health plan" has the meaning given in s. 632.745 (24).

(f) "Transitional treatment arrangements" means services for the treatment of nervous or mental disorders or alcoholism or other drug abuse problems that are provided to an insured in a less restrictive manner than are inpatient hospital services but in a more intensive manner than are outpatient services, and that are specified by the commissioner by rule under sub. (4).

(2) REQUIRED COVERAGE FOR GROUP PLANS. (a) *Conditions covered.* A group health benefit plan and a self–insured health plan shall provide coverage of nervous and mental disorders and alcoholism and other drug abuse problems if required by pars. (c) to (dm) and as provided in pars. (c) to (dm) and subs. (3) to (3f).

(c) *Coverage of inpatient hospital services.* If a group health benefit plan or a self–insured health plan provides coverage of any inpatient hospital treatment, the plan shall provide coverage for inpatient hospital services for the treatment of conditions under par. (a).

(d) *Coverage of outpatient services.* If a group health benefit plan or a self–insured health plan provides coverage of any outpatient treatment, the plan shall provide coverage for outpatient services for the treatment of conditions under par. (a).

(dm) *Coverage of transitional treatment arrangements.* If a group health benefit plan or a self–insured health plan provides coverage of any inpatient hospital treatment or any outpatient treatment, the plan shall provide coverage for transitional treatment arrangements for the treatment of conditions under par. (a).

(3) LIMITATIONS. For a group health benefit plan and a self–insured health plan that provide coverage of the treatment of nervous and mental disorders and alcoholism and other drug abuse problems, and for an individual health benefit plan that provides coverage of the treatment of nervous and mental disorders or alcoholism and other drug abuse problems, the exclusions and limitations; deductibles; copayments; coinsurance; annual and lifetime payment limitations; out–of–pocket limits; out–of–network charges; day, visit, or appointment limits; limitations regarding referrals to nonphysician providers and treatment programs; and duration or frequency of coverage limits under the plan may be no more restrictive for coverage of the treatment of nervous and mental disorders or alcoholism and other drug abuse problems than the most common or frequent type of treatment limitations applied to substantially all other coverage under the plan. The plan shall include in any overall deductible amount or annual or lifetime limit or out–of–pocket limit for the plan, expenses incurred for the treatment of nervous and mental disorders or alcoholism and other drug abuse problems.

(3c) EXEMPTION FOR COST INCREASE. (a) Notwithstanding sub. (3), an employer that provides health care coverage for its employees through a group health benefit plan or a self–insured health plan that provides coverage of the treatment of nervous and mental disorders and alcoholism and other drug abuse problems may elect for the employer's plan to be exempt from the require-

ments under sub. (3) during the plan year following any plan year in which, as a result of the requirements under sub. (3), there is an increase under the plan in the employer's total cost of coverage for the treatment of physical conditions and nervous and mental disorders and alcoholism and other drug abuse problems by a percentage that exceeds either of the following:

1. Two percent in the first plan year in which the requirements apply.

2. One percent in any plan year after the first plan year in which the requirements apply.

(b) A cost increase specified under par. (a) may not be determined until the employer's group health benefit plan or self–insured health plan has complied with the requirements under sub. (3) for at least the first 6 months of the plan year for which the increase is to be determined. The cost increase shall be determined, and certified, by a qualified actuary, as defined in s. 623.06 (1) (h). A copy of the actuary's determination, and all underlying documentation that the actuary relied on in making the determination, shall be filed with and, in accordance with rules promulgated by the commissioner, retained by the insurer issuing the group health benefit plan or by the self–insured health plan.

(c) A group health benefit plan or a self–insured health plan that qualifies for an exemption under par. (a) and for which the employer providing coverage under the plan has elected for the plan to be exempt from the requirements under sub. (3) during a plan year shall promptly notify all enrollees under the plan.

(d) Regardless of a cost increase as specified in par. (a), an employer may elect for the employer's plan to continue to be subject to the requirements under sub. (3). If an employer elects for the employer's plan to be exempt from the requirements under sub. (3), during the plan year in which it is exempt the group health benefit plan or self–insured health plan shall comply with the coverage requirements under s. 632.89 (2) (a) to (dm), 2007 stats.

(3f) EXEMPTION FOR SMALL EMPLOYERS. (a) Notwithstanding sub. (3), an employer that provides health care coverage for its employees through a group health benefit plan that provides coverage of the treatment of nervous and mental disorders and alcoholism and other drug abuse problems may elect for the employer's plan to be exempt from the requirements under sub. (3) during a plan year if, on the first day of the plan year, the employer will have fewer than 10 eligible employees, as defined in s. 632.745 (5).

(b) A group health benefit plan that qualifies for an exemption under par. (a) and for which the employer providing coverage under the plan has elected for the plan to be exempt from the requirements under sub. (3) during a plan year shall promptly notify all enrollees under the employer's plan. During the plan year in which it is exempt from the requirements under sub. (3), the group health benefit plan shall comply with the coverage requirements under s. 632.89 (2) (a) to (dm), 2007 stats.

(3p) AVAILABILITY OF PLAN INFORMATION. A group health benefit plan and a self–insured health plan that provide coverage of the treatment of nervous and mental disorders and alcoholism and other drug abuse problems, and an individual health benefit plan that provides coverage of the treatment of nervous and mental disorders or alcoholism and other drug abuse problems, shall, upon request, make available to any current or potential insured, participant, beneficiary, or contracting provider the criteria for determining medical necessity under the plan with respect to that coverage. If a group health benefit plan or a self–insured health plan that provides coverage of the treatment of nervous and mental disorders and alcoholism and other drug abuse problems denies any particular insured, participant, or beneficiary coverage for services for that treatment, or if an individual health benefit plan that provides coverage of the treatment of nervous and mental disorders or alcoholism and other drug abuse problems denies any particular insured coverage for services for that treatment, the plan shall, upon request, make the reason for the denial available to the insured, participant, or beneficiary, in addition to complying with s. 632.857, if applicable.

(4) RULES. (a) The commissioner shall specify by rule the services for the treatment of nervous or mental disorders or alcoholism or other drug abuse problems, including but not limited to day hospitalization, that are covered under sub. (2) (dm).

(b) 1. The commissioner shall promulgate rules for the administration of this section, including rules that specify the information that must be provided in the notices under subs. (3c) (c) and (3f) (b) and the manner in which the notices must be given, that specify who is responsible for the actuarial study and determination under sub. (3c) (b), and that specify retention requirements for the determination and underlying documentation. In promulgating the rules, the commissioner shall follow, as a minimum standard, any relevant federal regulations or guidelines that are in effect.

2. Using the procedure under s. 227.24, the commissioner may promulgate the rules under subd. 1. for the period before the effective date of any permanent rules promulgated under subd. 1., but not to exceed the period authorized under s. 227.24 (1) (c) and (2). Notwithstanding s. 227.24 (1) (a), (2) (b), and (3), the commissioner is not required to provide evidence that promulgating a rule under this subdivision as an emergency rule is necessary for the preservation of the public peace, health, safety, or welfare and is not required to make a finding of emergency for a rule promulgated under this subdivision.

(4m) LIABILITY TO THE STATE OR COUNTY. For any insurance policy issued on or after January 1, 1981, any insurer providing hospital treatment coverage is liable to the state or county for any costs incurred for services an inpatient health care facility, as defined in s. 50.135 (1), or community–based residential facility, as defined in s. 50.01 (1g), owned or operated by a state or county, provides to a patient regardless of the patient's liability for the services, to the extent that the insurer is liable to the patient for services provided at any other inpatient health care facility or community–based residential facility.

(5) EXCLUSIONS. (a) *Medicare.* No insurer or other organization subject to this section is required to duplicate coverage available under the federal medicare program.

(b) *Certain health care plans.* This section does not apply to a health care plan offered by a limited service health organization, as defined in s. 609.01 (3), or by a preferred provider plan, as defined in s. 609.01 (4), that is not a defined network plan, as defined in s. 609.01 (1b).

(c) *Coverage of autism treatment.* This section does not apply to coverage of treatment for autism spectrum disorder, as defined in s. 632.895 (12m) (a) 1., to which s. 632.895 (12m) applies.

History: 1975 c. 223, 224, 375; 1977 c. 203 s. 106; 1979 c. 175, 221; 1981 c. 20 s. 2202 (20) (q); 1981 c. 39 ss. 14, 15, 22; 1981 c. 314; 1983 a. 27; 1983 a. 189 s. 329 (5); 1985 a. 29, 176; 1987 a. 195, 403; 1991 a. 39, 250; 1993 a. 27, 270; 1995 a. 27 ss. 7047, 9126 (19); 1997 a. 27; 1999 a. 9; 2003 a. 178; 2007 a. 20 s. 9121 (6) (a); 2009 a. 28, 218; 2015 a. 90.

Cross–reference: See also ss. Ins 3.37 and 3.375, Wis. adm. code.

632.895 Mandatory coverage. (1) DEFINITIONS. In this section:

(a) "Disability insurance policy" means surgical, medical, hospital, major medical or other health service coverage but does not include hospital indemnity policies or ancillary coverages such as income continuation, loss of time or accident benefits.

(b) "Home care" means care and treatment of an insured under a plan of care established, approved in writing and reviewed at least every 2 months by the attending physician, unless the attending physician determines that a longer interval between reviews is sufficient, and consisting of one or more of the following:

1. Part–time or intermittent home nursing care by or under the supervision of a registered nurse.

2. Part–time or intermittent home health services that are medically necessary as part of the home care plan, under the

supervision of a registered nurse or medical social worker, which consist solely of caring for the patient.

3. Physical or occupational therapy or speech–language pathology or respiratory care.

4. Medical supplies, drugs and medications prescribed by a physician and laboratory services by or on behalf of a hospital, if necessary under the home care plan, to the extent such items would be covered under the policy if the insured had been hospitalized.

5. Nutrition counseling provided by or under the supervision of one of the following, where such services are medically necessary as part of the home care plan:

a. A registered dietitian.

b. A dietitian certified under subch. V of ch. 448, if the nutrition counseling is provided on or after July 1, 1995.

6. The evaluation of the need for and development of a plan, by a registered nurse, physician extender or medical social worker, for home care when approved or requested by the attending physician.

(c) "Hospital indemnity policies" means policies which provide benefits in a stated amount for confinement in a hospital, regardless of the hospital expenses actually incurred by the insured, due to such confinement.

(d) "Immediate family" means the spouse, children, parents, grandparents, brothers and sisters of the insured and their spouses.

(2) HOME CARE. (a) Every disability insurance policy which provides coverage of expenses incurred for inpatient hospital care shall provide coverage for the usual and customary fees for home care. Such coverage shall be subject to the same deductible and coinsurance provisions of the policy as other covered services. The maximum weekly benefit for such coverage need not exceed the usual and customary weekly cost for care in a skilled nursing facility. If an insurer provides disability insurance, or if 2 or more insurers jointly provide disability insurance, to an insured under 2 or more policies, home care coverage is required under only one of the policies.

(b) Home care shall not be reimbursed unless the attending physician certifies that:

1. Hospitalization or confinement in a skilled nursing facility would otherwise be required if home care was not provided.

2. Necessary care and treatment are not available from members of the insured's immediate family or other persons residing with the insured without causing undue hardship.

3. The home care services shall be provided or coordinated by a state–licensed or medicare–certified home health agency or certified rehabilitation agency.

(c) If the insured was hospitalized immediately prior to the commencement of home care, the home care plan shall also be initially approved by the physician who was the primary provider of services during the hospitalization.

(d) Each visit by a person providing services under a home care plan or evaluating the need for or developing a plan shall be considered as one home care visit. The policy may contain a limit on the number of home care visits, but not less than 40 visits in any 12–month period, for each person covered under the policy. Up to 4 consecutive hours in a 24–hour period of home health service shall be considered as one home care visit.

(e) Every disability insurance policy which purports to provide coverage supplementing parts A and B of Title XVIII of the social security act shall make available and if requested by the insured provide coverage of supplemental home care visits beyond those provided by parts A and B, sufficient to produce an aggregate coverage of 365 home care visits per policy year.

(f) This subsection does not require coverage for any services provided by members of the insured's immediate family or any other person residing with the insured.

(g) Insurers reviewing the certified statements of physicians as to the appropriateness and medical necessity of the services certified by the physician under this subsection may apply the same review criteria and standards which are utilized by the insurer for all other business.

(3) SKILLED NURSING CARE. Every disability insurance policy filed after November 29, 1979, which provides coverage for hospital care shall provide coverage for at least 30 days for skilled nursing care to patients who enter a licensed skilled nursing care facility. A disability insurance policy, other than a medicare supplement policy or medicare replacement policy, may limit coverage under this subsection to patients who enter a licensed skilled nursing care facility within 24 hours after discharge from a general hospital. The daily rate payable under this subsection to a licensed skilled nursing care facility shall be no less than the maximum daily rate established for skilled nursing care in that facility by the department of health services for purposes of reimbursement under the medical assistance program under subch. IV of ch. 49. The coverage under this subsection shall apply only to skilled nursing care which is certified as medically necessary by the attending physician and is recertified as medically necessary every 7 days. If the disability insurance policy is other than a medicare supplement policy or medicare replacement policy, coverage under this subsection shall apply only to the continued treatment for the same medical or surgical condition for which the insured had been treated at the hospital prior to entry into the skilled nursing care facility. Coverage under any disability insurance policy governed by this subsection may be subject to a deductible that applies to the hospital care coverage provided by the policy. The coverage under this subsection shall not apply to care which is essentially domiciliary or custodial, or to care which is available to the insured without charge or under a governmental health care program, other than a program provided under ch. 49.

(4) KIDNEY DISEASE TREATMENT. (a) Every disability insurance policy which provides hospital treatment coverage on an expense incurred basis shall provide coverage for hospital inpatient and outpatient kidney disease treatment, which may be limited to dialysis, transplantation and donor–related services, in an amount not less than $30,000 annually, as defined by the department of health services under par. (d).

(b) No insurer is required to duplicate coverage available under the federal medicare program, nor duplicate any other insurance coverage the insured may have. Other insurance coverage does not include public assistance under ch. 49.

(c) Coverage under this subsection may not be subject to exclusions or limitations, including deductibles and coinsurance factors, which are not generally applicable to other conditions covered under the policy.

(d) The department of health services may by rule impose reasonable standards for the treatment of kidney diseases required to be covered under this subsection, which shall not be inconsistent with or less stringent than applicable federal standards.

(5) COVERAGE OF NEWBORN INFANTS. (a) Every disability insurance policy shall provide coverage for a newly born child of the insured from the moment of birth.

(b) Coverage for newly born children required under this subsection shall consider congenital defects and birth abnormalities as an injury or sickness under the policy and shall cover functional repair or restoration of any body part when necessary to achieve normal body functioning, but shall not cover cosmetic surgery performed only to improve appearance.

(c) If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy may require that notification of the birth of a child and payment of the required premium or fees shall be furnished to the insurer within 60 days after the date of birth. The insurer may refuse to continue coverage beyond the 60–day period if such notification is not received, unless within one year after the birth of the child the insured makes all past–due payments and in addition pays interest on such payments at the rate of 5 1/2 percent per year.

(d) If payment of a specific premium or subscription fee is not required to provide coverage for a child, the policy or contract may request notification of the birth of a child but may not deny or refuse to continue coverage if such notification is not furnished.

(e) This subsection applies to all policies issued or renewed after May 5, 1976, and to all policies in existence on June 1, 1976. All policies issued or renewed after June 1, 1976, shall be amended to comply with the requirements of this subsection.

(5m) COVERAGE OF GRANDCHILDREN. Every disability insurance policy issued or renewed on or after May 7, 1986, that provides coverage for any child of the insured shall provide the same coverage for all children of that child until that child is 18 years of age.

(6) EQUIPMENT AND SUPPLIES FOR TREATMENT OF DIABETES. Every disability insurance policy which provides coverage of expenses incurred for treatment of diabetes shall provide coverage for expenses incurred by the installation and use of an insulin infusion pump, coverage for all other equipment and supplies, including insulin or any other prescription medication, used in the treatment of diabetes, and coverage of diabetic self–management education programs. Coverage required under this subsection shall be subject to the same exclusions, limitations, deductibles, and coinsurance provisions of the policy as other covered expenses, except that insulin infusion pump coverage may be limited to the purchase of one pump per year and the insurer may require the insured to use a pump for 30 days before purchase.

(7) MATERNITY COVERAGE. Every group disability insurance policy which provides maternity coverage shall provide maternity coverage for all persons covered under the policy. Coverage required under this subsection may not be subject to exclusions or limitations which are not applied to other maternity coverage under the policy.

(8) COVERAGE OF MAMMOGRAMS. (a) In this subsection:

1. "Direction" means verbal or written instructions, standing orders or protocols.

2. "Low–dose mammography" means the X–ray examination of a breast using equipment dedicated specifically for mammography, including the X–ray tube, filter, compression device, screens, films and cassettes, with an average radiation exposure delivery of less than one rad mid–breast, with 2 views for each breast.

3. "Nurse practitioner" means an individual who is licensed as a registered nurse under ch. 441 or the laws of another state and who satisfies any of the following:

a. Is certified as a primary care nurse practitioner or clinical nurse specialist by the American nurses' association or by the national board of pediatric nurse practitioners and associates.

am. Holds a master's degree in nursing from an accredited school of nursing.

b. Before March 31, 1990, has successfully completed a formal one–year academic program that prepares registered nurses to perform an expanded role in the delivery of primary care, includes at least 4 months of classroom instruction and a component of supervised clinical practice, and awards a degree, diploma or certificate to individuals who successfully complete the program.

c. Has successfully completed a formal education program that is intended to prepare registered nurses to perform an expanded role in the delivery of primary care but that does not meet the requirements of subd. 3. b., and has performed an expanded role in the delivery of primary care for a total of 12 months during the 18–month period immediately before July 1, 1978.

(b) 1. Except as provided in subd. 2. and par. (f), every disability insurance policy that provides coverage for a woman age 45 to 49 shall provide coverage for that woman of 2 examinations by low–dose mammography performed when the woman is age 45 to 49, if all of the following are satisfied:

a. Each examination by low–dose mammography is performed at the direction of a licensed physician or a nurse practitioner, except as provided in par. (e).

b. The woman has not had an examination by low–dose mammography within 2 years before each examination is performed.

2. A disability insurance policy need not provide coverage under subd. 1. to the extent that the woman had obtained one or more examinations by low–dose mammography while between the ages of 45 and 49 and before obtaining coverage under the disability insurance policy.

(c) Except as provided in par. (f), every disability insurance policy that provides coverage for a woman age 50 or older shall provide coverage for that woman of an annual examination by low–dose mammography to screen for the presence of breast cancer, if the examination is performed at the direction of a licensed physician or a nurse practitioner or if par. (e) applies.

(d) Coverage is required under this subsection despite whether the woman shows any symptoms of breast cancer. Except as provided in pars. (b), (c) and (e), coverage under this subsection may only be subject to exclusions and limitations, including deductibles, copayments and restrictions on excessive charges, that are applied to other radiological examinations covered under the disability insurance policy.

(e) A disability insurance policy shall cover an examination by low–dose mammography that is not performed at the direction of a licensed physician or a nurse practitioner but that is otherwise required to be covered under par. (b) or (c), if all of the following are satisfied:

1. The woman does not have an assigned or regular physician or nurse practitioner when the examination is performed.

2. The woman designates a physician to receive the results of the examination.

3. Any examination by low–dose mammography previously obtained by the woman was at the direction of a licensed physician or a nurse practitioner.

(f) This subsection does not apply to any of the following:

1. A disability insurance policy that only provides coverage of certain specified diseases.

2. A health care plan offered by a limited service health organization, as defined in s. 609.01 (3).

3. A medicare replacement policy, a medicare supplement policy or a long–term care insurance policy.

(9) DRUGS FOR TREATMENT OF HIV INFECTION. (a) In this subsection, "HIV infection" means the pathological state produced by a human body in response to the presence of HIV, as defined in s. 631.90 (1).

(b) Except as provided in par. (d), every disability insurance policy that is issued or renewed on or after April 28, 1990, and that provides coverage of prescription medication shall provide coverage for each drug that satisfies all of the following:

1. Is prescribed by the insured's physician for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection.

2. Is approved by the federal food and drug administration for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection, including each investigational new drug that is approved under 21 CFR 312.34 to 312.36 for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection and that is in, or has completed, a phase 3 clinical investigation performed in accordance with 21 CFR 312.20 to 312.33.

3. If the drug is an investigational new drug described in subd. 2., is prescribed and administered in accordance with the treatment protocol approved for the investigational new drug under 21 CFR 312.34 to 312.36.

(c) Coverage of a drug under par. (b) may be subject to any copayments and deductibles that the disability insurance policy

applies generally to other prescription medication covered by the disability insurance policy.

(d) This subsection does not apply to any of the following:

1. A disability insurance policy that covers only certain specified diseases.

2. A health care plan offered by a limited service health organization, as defined in s. 609.01 (3).

3. A medicare replacement policy or a medicare supplement policy.

(10) LEAD POISONING SCREENING. (a) Except as provided in par. (b), every disability insurance policy and every health care benefits plan provided on a self–insured basis by a county board under s. 59.52 (11), by a city or village under s. 66.0137 (4), by a local governmental unit or technical college district under s. 66.0137 (4m), by a town under s. 60.23 (25), or by a school district under s. 120.13 (2) shall provide coverage for blood lead tests for children under 6 years of age, which shall be conducted in accordance with any recommended lead screening methods and intervals contained in any rules promulgated by the department of health services under s. 254.158.

(b) This subsection does not apply to any of the following:

1. A disability insurance policy that covers only certain specified diseases.

2. A health care plan offered by a limited service health organization, as defined in s. 609.01 (3).

3. A long–term care insurance policy, as defined in s. 600.03 (28g).

4. A medicare replacement policy, as defined in s. 600.03 (28p).

5. A medicare supplement policy, as defined in s. 600.03 (28r).

(11) TREATMENT FOR THE CORRECTION OF TEMPOROMANDIBULAR DISORDERS. (a) Except as provided in par. (e), every disability insurance policy, and every self–insured health plan of the state or a county, city, village, town or school district, that provides coverage of any diagnostic or surgical procedure involving a bone, joint, muscle or tissue shall provide coverage for diagnostic procedures and medically necessary surgical or nonsurgical treatment for the correction of temporomandibular disorders if all of the following apply:

1. The condition is caused by congenital, developmental or acquired deformity, disease or injury.

2. Under the accepted standards of the profession of the health care provider rendering the service, the procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition.

3. The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

(b) 1. The coverage required under this subsection for nonsurgical treatment includes coverage for prescribed intraoral splint therapy devices.

2. The coverage required under this subsection does not include coverage for cosmetic or elective orthodontic care, periodontic care or general dental care.

(c) 1. The coverage required under this subsection may be subject to any limitations, exclusions or cost–sharing provisions that apply generally under the disability insurance policy or self–insured health plan.

2. Notwithstanding subd. 1., the coverage required under this subsection for diagnostic procedures and medically necessary nonsurgical treatment for the correction of temporomandibular disorders may not exceed $1,250 annually.

(d) Notwithstanding par. (c) 1., an insurer or a self–insured health plan of the state or a county, city, village, town or school district may require that an insured obtain prior authorization for any medically necessary surgical or nonsurgical treatment for the correction of temporomandibular disorders.

(e) This subsection does not apply to any of the following:

1. A disability insurance policy that covers only dental care.

2. A medicare supplement policy, as defined in s. 600.03 (28r).

(12) HOSPITAL AND AMBULATORY SURGERY CENTER CHARGES AND ANESTHETICS FOR DENTAL CARE. (a) In this subsection, "ambulatory surgery center" has the meaning given in 42 CFR 416.2.

(b) Except as provided in par. (d), every disability insurance policy, and every self–insured health plan of the state or a county, city, village, town or school district, shall cover hospital or ambulatory surgery center charges incurred, and anesthetics provided, in conjunction with dental care that is provided to a covered individual in a hospital or ambulatory surgery center, if any of the following applies:

1. The individual is a child under the age of 5.

2. The individual has a chronic disability that meets all of the conditions under s. 230.04 (9r) (a) 2. a., b. and c.

3. The individual has a medical condition that requires hospitalization or general anesthesia for dental care.

(c) The coverage required under this subsection may be subject to any limitations, exclusions or cost–sharing provisions that apply generally under the disability insurance policy or self–insured plan.

(d) This subsection does not apply to a disability insurance policy that covers only dental care.

(12m) TREATMENT FOR AUTISM SPECTRUM DISORDERS. (a) In this subsection:

1. "Autism spectrum disorder" means any of the following:

a. Autism disorder.

b. Asperger's syndrome.

c. Pervasive developmental disorder not otherwise specified.

2. "Insured" includes an enrollee and a dependent with coverage under the disability insurance policy or self–insured health plan.

3. "Intensive–level services" means evidence–based behavioral therapy that is designed to help an individual with autism spectrum disorder overcome the cognitive, social, and behavioral deficits associated with that disorder.

4. "Nonintensive–level services" means evidence–based therapy that occurs after the completion of treatment with intensive–level services and that is designed to sustain and maximize gains made during treatment with intensive–level services or, for an individual who has not and will not receive intensive–level services, evidence–based therapy that will improve the individual's condition.

5. "Physician" has the meaning given in s. 146.34 (1) (g).

(b) Subject to pars. (c) and (d), and except as provided in par. (e), every disability insurance policy, and every self–insured health plan of the state or a county, city, town, village, or school district, shall provide coverage for an insured of treatment for the mental health condition of autism spectrum disorder if the treatment is prescribed by a physician and provided by any of the following who are qualified to provide intensive–level services or nonintensive–level services:

1. A psychiatrist, as defined in s. 146.34 (1) (h).

2. A person who practices psychology, as described in s. 455.01 (5).

3. A social worker, as defined in s. 252.15 (1) (er), who is certified or licensed to practice psychotherapy, as defined in s. 457.01 (8m).

3m. A behavior analyst who is licensed under s. 440.312.

4. A paraprofessional working under the supervision of a provider listed under subds. 1. to 3m.

5. A professional working under the supervision of an outpatient mental health clinic certified under s. 51.038.

6. A speech–language pathologist, as defined in s. 459.20 (4).

7. An occupational therapist, as defined in s. 448.96 (4).

(c) 1. The coverage required under par. (b) shall provide at least $50,000 for intensive–level services per insured per year, with a minimum of 30 to 35 hours of care per week for a minimum duration of 4 years, and at least $25,000 for nonintensive–level services per insured per year, except that these minimum coverage monetary amounts shall be adjusted annually, beginning in 2011, to reflect changes in the consumer price index for all urban consumers, U.S. city average, for the medical care group, as determined by the U.S. department of labor. The commissioner shall publish the new minimum coverage amounts under this subdivision each year, beginning in 2011, in the Wisconsin Administrative Register.

2. Notwithstanding subd. 1., the minimum coverage monetary amounts or duration required for treatment under subd. 1., need not be met if it is determined by a supervising professional, in consultation with the insured's physician, that less treatment is medically appropriate.

(d) The coverage required under par. (b) may be subject to deductibles, coinsurance, or copayments that generally apply to other conditions covered under the policy or plan. The coverage may not be subject to limitations or exclusions, including limitations on the number of treatment visits.

(e) This subsection does not apply to any of the following:

1. A disability insurance policy that covers only certain specified diseases.

2. A health care plan offered by a limited service health organization, as defined in s. 609.01 (3), or by a preferred provider plan, as defined in s. 609.01 (4), that is not a defined network plan, as defined in s. 609.01 (1b).

3. A long–term care insurance policy.

4. A medicare replacement policy or a medicare supplement policy.

(f) 1. The commissioner shall by rule further define "intensive–level services" and "nonintensive–level services" and define "paraprofessional" for purposes of par. (b) 4. and "qualified" for purposes of providing services under this subsection. The commissioner may promulgate rules governing the interpretation or administration of this subsection.

2. Using the procedure under s. 227.24, the commissioner may promulgate the rules under subd. 1. for the period before the effective date of the permanent rules promulgated under subd. 1., but not to exceed the period authorized under s. 227.24 (1) (c) and (2). Notwithstanding s. 227.24 (1) (a), (2) (b), and (3), the commissioner is not required to provide evidence that promulgating a rule under this subdivision as an emergency rule is necessary for the preservation of the public peace, health, safety, or welfare and is not required to provide a finding of emergency for a rule promulgated under this subdivision.

(13) BREAST RECONSTRUCTION. (a) Every disability insurance policy, and every self–insured health plan of the state or a county, city, village, town or school district, that provides coverage of the surgical procedure known as a mastectomy shall provide coverage of breast reconstruction of the affected tissue incident to a mastectomy.

(b) The coverage required under par. (a) may be subject to any limitations, exclusions or cost–sharing provisions that apply generally under the disability insurance policy or self–insured health plan.

(14) COVERAGE OF IMMUNIZATIONS. (a) In this subsection:

1. "Appropriate and necessary immunizations" means the administration of vaccine that meets the standards approved by the U.S. public health service for such biological products against at least all of the following:

a. Diphtheria.

b. Pertussis.

c. Tetanus.

d. Polio.

e. Measles.

f. Mumps.

g. Rubella.

h. Hemophilus influenza B.

i. Hepatitis B.

j. Varicella.

2. "Dependent" means a spouse, an unmarried child under the age of 19 years, an unmarried child who is a full–time student under the age of 21 years and who is financially dependent upon the parent, or an unmarried child of any age who is medically certified as disabled and who is dependent upon the parent.

(b) Except as provided in par. (d), every disability insurance policy, and every self–insured health plan of the state or a county, city, town, village or school district, that provides coverage for a dependent of the insured shall provide coverage of appropriate and necessary immunizations, from birth to the age of 6 years, for a dependent who is a child of the insured.

(c) The coverage required under par. (b) may not be subject to any deductibles, copayments, or coinsurance under the policy or plan. This paragraph applies to a defined network plan, as defined in s. 609.01 (1b), only with respect to appropriate and necessary immunizations provided by providers participating, as defined in s. 609.01 (3m), in the plan.

(d) This subsection does not apply to any of the following:

1. A disability insurance policy that covers only certain specified diseases.

2. A disability insurance policy that covers only hospital and surgical charges.

3. A health care plan offered by a limited service health organization, as defined in s. 609.01 (3), or by a preferred provider plan, as defined in s. 609.01 (4), that is not a defined network plan, as defined in s. 609.01 (1b).

4. A long–term care insurance policy, as defined in s. 600.03 (28g).

5. A medicare replacement policy, as defined in s. 600.03 (28p).

6. A medicare supplement policy, as defined in s. 600.03 (28r).

(14g) COVERAGE OF COVID–19 TESTING. (a) In this subsection, "COVID–19" means an infection caused by the SARS–CoV–2 coronavirus.

(b) Before March 13, 2021, every disability insurance policy, and every self–insured health plan of the state or of a county, city, town, village, or school district, that generally covers testing for infectious diseases shall provide coverage of testing for COVID–19 without imposing any copayment or coinsurance on the individual covered under the policy or plan.

(15) COVERAGE OF STUDENT ON MEDICAL LEAVE. (a) Subject to pars. (b) and (c), every disability insurance policy, and every self–insured health plan of the state or a county, city, town, village, or school district, that provides coverage for a person as a dependent of the insured because the person is a full–time student, including the coverage under s. 632.885 (2) (b), shall continue to provide dependent coverage for the person if, due to a medically necessary leave of absence, he or she ceases to be a full–time student.

(b) A policy or plan is not required to continue coverage under par. (a) unless the person submits documentation and certification of the medical necessity of the leave of absence from the person's attending physician. The date on which the person ceases to be a full–time student due to the medically necessary leave of absence shall be the date on which the coverage continuation under par. (a) begins.

(c) A policy or plan is required to continue coverage under par. (a) only until any of the following occurs:

1. The person advises the policy or plan that he or she does not intend to return to school full time.

2. The person becomes employed full time.

3. The person obtains other health care coverage.

4. The person marries and is eligible for coverage under his or her spouse's health care coverage.

5. Except for a person who has coverage as a dependent under s. 632.885 (2) (b), the person reaches the age at which coverage as a dependent who is a full–time student would otherwise end under the terms and conditions of the policy or plan.

6. Coverage of the insured through whom the person has dependent coverage under the policy or plan is discontinued or not renewed.

7. One year has elapsed since the person's coverage continuation under par. (a) began and the person has not returned to school full time.

(16) HEARING AIDS, COCHLEAR IMPLANTS, AND RELATED TREATMENT FOR INFANTS AND CHILDREN. (a) In this subsection:

1. "Cochlear implant" includes any implantable instrument or device that is designed to enhance hearing.

2. "Hearing aid" means any externally wearable instrument or device designed for or offered for the purpose of aiding or compensating for impaired human hearing and any parts, attachments, or accessories of such an instrument or device, except batteries and cords.

3. "Physician" has the meaning given in s. 448.01 (5).

4. "Self–insured health plan" means a self–insured health plan of the state or a county, city, village, town, or school district.

5. "Treatment" means services, diagnoses, procedures, surgery, and therapy provided by a health care professional.

(b) 1. Except as provided in par. (c), every disability insurance policy and every self–insured health plan shall provide the following coverages:

a. Coverage of the cost of hearing aids and cochlear implants that are prescribed by a physician, or by an audiologist licensed under subch. II of ch. 459, in accordance with accepted professional medical or audiological standards, for a child covered under the policy or plan who is under 18 years of age and who is certified as deaf or hearing impaired by a physician or by an audiologist licensed under subch. II of ch. 459.

b. Coverage of the cost of treatment related to hearing aids and cochlear implants, including procedures for the implantation of cochlear devices, for a child specified in subd. 1. a.

2. Coverage of the cost of hearing aids under this subsection is not required to exceed the cost of one hearing aid per ear per child more often than once every 3 years.

3. The coverage required under this subsection may be subject to any cost–sharing provisions, limitations, or exclusions, other than a preexisting condition exclusion, that apply generally under the disability insurance policy or self–insured health plan.

(c) This subsection does not apply to any of the following:

1. A disability insurance policy that covers only certain specified diseases.

2. A disability insurance policy, or a self–insured health plan of the state or a county, city, town, village, or school district, that provides only limited–scope dental or vision benefits.

3. A health care plan offered by a limited service health organization, as defined in s. 609.01 (3), or by a preferred provider plan, as defined in s. 609.01 (4), that is not a defined network plan, as defined in s. 609.01 (1b).

4. A long–term care insurance policy.

5. A medicare replacement policy or a medicare supplement policy.

5m. An individual health benefit plan that is not renewable and that has a specified termination date that, including any extensions that the policyholder may elect without the insurer's consent, is less than 12 months after the original effective date.

(16m) COLORECTAL CANCER SCREENING. (a) Except as provided in par. (c), every disability insurance policy, and every self–insured health plan of the state or a county, city, village, town, or school district, that provides coverage of any diagnostic or surgical procedures shall provide coverage of colorectal cancer examinations and laboratory tests, in accordance with guidelines specified by the commissioner by rule under par. (d) 1. and 3., for all of the following:

1. An insured or enrollee who is 50 years of age or older.

2. An insured or enrollee who is under 50 years of age and at high risk for colorectal cancer, as specified by the commissioner by rule under par. (d) 2. and 3.

(b) The coverage required under this subsection may be subject to any limitations, exclusions, or cost–sharing provisions that apply generally under the disability insurance policy or self–insured health plan.

(c) This subsection does not apply to any of the following:

1. A disability insurance policy that covers only certain specified diseases.

2. A health care plan offered by a limited service health organization, as defined in s. 609.01 (3), or by a preferred provider plan, as defined in s. 609.01 (4), that is not a defined network plan, as defined in s. 609.01 (1b).

3. A disability insurance policy, or a self–insured health plan of the state or a county, city, town, village, or school district, that provides only limited–scope dental or vision benefits.

(d) The commissioner, in consultation with the secretary of health services and after considering nationally validated guidelines, including guidelines issued by the American Cancer Society for colorectal cancer screening, shall promulgate rules that do all of the following:

1. Specify guidelines for the colorectal cancer screening that must be covered under this subsection.

2. Specify the factors for determining whether an individual is at high risk for colorectal cancer.

3. Periodically update the guidelines under subd. 1. and the factors under subd. 2., as medically appropriate.

Cross–reference: See also s. Ins 3.35, Wis. adm. code.

(16t) PRESCRIPTION EYE DROPS. Every disability insurance policy and every self–insured health plan of the state or of a county, city, town, village, or school district that provides coverage of prescription eye drops shall cover a refill of the prescription eye drops that satisfies all of the following:

(a) The refill is requested by the insured or plan participant when 75 percent or more of the days have elapsed from the later of the original date the prescription was distributed to the insured or plan participant or the date on which the most recent refill was distributed to the insured or plan participant.

(b) The prescription allows for a refill of the prescription eye drops.

(c) The requested refill does not exceed the number of refills allowed by the prescription.

(16v) PROHIBITING COVERAGE LIMITATIONS ON PRESCRIPTION DRUGS. (a) During the period covered by the state of emergency related to public health declared by the governor on March 12, 2020, by executive order 72, an insurer offering a disability insurance policy that covers prescription drugs, a self–insured health plan of the state or of a county, city, town, village, or school district that covers prescription drugs, or a pharmacy benefit manager acting on behalf of a policy or plan may not do any of the following in order to maintain coverage of a prescription drug:

1. Require prior authorization for early refills of a prescription drug or otherwise restrict the period of time in which a prescription drug may be refilled.

2. Impose a limit on the quantity of prescription drugs that may be obtained if the quantity is no more than a 90–day supply.

(b) This subsection does not apply to a prescription drug that is a controlled substance, as defined in s. 961.01 (4).

(17) CONTRACEPTIVES AND SERVICES. (a) In this subsection, "contraceptives" means drugs or devices approved by the federal food and drug administration to prevent pregnancy.

(b) Every disability insurance policy, and every self–insured health plan of the state or of a county, city, town, village, or school district, that provides coverage of outpatient health care services, preventive treatments and services, or prescription drugs and devices shall provide coverage for all of the following:

1. Contraceptives prescribed by a health care provider, as defined in s. 146.81 (1).

2. Outpatient consultations, examinations, procedures, and medical services that are necessary to prescribe, administer, maintain, or remove a contraceptive, if covered for any other drug benefits under the policy or plan.

(c) Coverage under par. (b) may be subject only to the exclusions, limitations, or cost–sharing provisions that apply generally to the coverage of outpatient health care services, preventive treatments and services, or prescription drugs and devices that is provided under the policy or self–insured health plan.

(d) This subsection does not apply to any of the following:

1. A disability insurance policy that covers only certain specified diseases.

2. A disability insurance policy, or a self–insured health plan of the state or a county, city, town, village, or school district, that provides only limited–scope dental or vision benefits.

3. A health care plan offered by a limited service health organization, as defined in s. 609.01 (3), or by a preferred provider plan, as defined in s. 609.01 (4), that is not a defined network plan, as defined in s. 609.01 (1b).

4. A long–term care insurance policy.

5. A Medicare replacement policy or a Medicare supplement policy.

History: 1981 c. 39 ss. 4 to 12, 18, 20; 1981 c. 85, 99; 1981 c. 314 ss. 122, 123, 125; 1983 a. 36, 429; 1985 a. 29, 56, 311; 1987 a. 195, 327, 403; 1989 a. 129, 201, 229, 316, 332, 359; 1991 a. 32, 45, 123; 1993 a. 443, 450; 1995 a. 27 ss. 7048, 9126 (19); 1995 a. 201, 225; 1997 a. 27, 35, 75, 175, 237; 1999 a. 32, 115; 1999 a. 150 s. 672; 2001 a. 16, 82; 2007 a. 20 s. 9121 (6) (a); 2007 a. 36, 153; 2009 a. 14, 28, 282, 346; 2011 a. 260 s. 80; 2015 a. 55; 2017 a. 305; 2019 a. 185.

Cross–reference: See also ss. Ins 3.38 and 3.54, Wis. adm. code.

The commissioner can reasonably construe sub. (3) to require an insurer to pay a facility's charge for care up to the maximum department of health and social services rate. Mutual Benefit v. Insurance Commissioner, 151 Wis. 2d 411, 444 N.W.2d 450 (Ct. App. 1989).

Sub. (2) (g) does not prohibit an insurer from contracting away the right to review medical necessity. The provision does not apply until the insurer has shown that its own determination is relevant to a insurance contract. Schroeder v. Blue Cross & Blue Shield, 153 Wis. 2d 165, 450 N.W.2d 470 (Ct. App. 1989).

Sub. (7) permits an insurer to exclude or limit certain services and procedures, as long as the exclusion or limitation applies to all policies. However, an insurer may not make routine maternity services that are generally covered under the policy unavailable to a specific subgroup of insureds, surrogate mothers, based solely on the insured's reasons for becoming pregnant or the method used to achieve pregnancy. Mercycare Ins. Co. v. Wisconsin Commissioner of Insurance, 2010 WI 87, 328 Wis. 2d 110, 786 N.W.2d 785, 08–2937.

632.896 Mandatory coverage of adopted children. (1) DEFINITIONS. In this section:

(a) "Department" means the department of health services.

(b) "Disability insurance policy" has the meaning given in s. 632.895 (1) (a).

(c) "Placed for adoption" means any of the following:

1. The department, a county department under s. 48.57 (1) (e) or (hm), or a child welfare agency licensed under s. 48.60 places a child in the insured's home for adoption and enters into an agreement under s. 48.63 (3) (b) 4. or 48.833 (1) or (2) with the insured.

2. The department, a county department under s. 48.57 (1) (e) or (hm), or a child welfare agency under s. 48.837 (1r) places, or a court under s. 48.837 (4) (d) or (6) (b) orders, a child placed in the insured's home for adoption.

3. A sending agency, as defined in s. 48.988 (2) (d), places a child in the insured's home under s. 48.988 for adoption, or a public child placing agency, as defined in s. 48.99 (2) (r), or a private child placing agency, as defined in s. 48.99 (2) (p), of a sending state, as defined in s. 48.99 (2) (w), places a child in the insured's home under s. 48.99 as a preliminary step to a possible adoption, and the insured takes physical custody of the child at any location within the United States.

4. The person bringing the child into this state has complied with s. 48.98, and the insured takes physical custody of the child at any location within the United States.

5. A court of a foreign jurisdiction appoints the insured as guardian of a child who is a citizen of that jurisdiction, and the child arrives in the insured's home for the purpose of adoption by the insured under s. 48.839.

(2) ADOPTED OR PLACED FOR ADOPTION. Every disability insurance policy that is issued or renewed on or after March 1, 1991, and that provides coverage for dependent children of the insured, as defined in the disability insurance policy, shall cover adopted children of the insured and children placed for adoption with the insured, on the same terms and conditions, including exclusions, limitations, deductibles and copayments, as other dependent children, except as provided in subs. (3) to (6).

(3) WHEN COVERAGE BEGINS AND ENDS. (a) 1. Coverage of a child under this section shall begin on the date that a court makes a final order granting adoption of the child by the insured or on the date that the child is placed for adoption with the insured, whichever occurs first.

2. Subdivision 1. does not require coverage to begin before coverage is available under the disability insurance policy for other dependent children.

(b) Coverage of a child placed for adoption with the insured is required under this section despite whether a court ultimately makes a final order granting adoption of the child by the insured. If adoption of a child who is placed for adoption with the insured is not finalized, the insurer may terminate coverage of the child when the child's adoptive placement with the insured terminates.

(4) PREEXISTING CONDITIONS. Notwithstanding ss. 632.746 and 632.76 (2) (a), a disability insurance policy that is subject to sub. (2) and that is in effect when a court makes a final order granting adoption or when the child is placed for adoption may not exclude or limit coverage of a disease or physical condition of the child on the ground that the disease or physical condition existed before coverage is required to begin under sub. (3).

(6) NOTICE TO INSURER. The disability insurance policy may require the insured to notify the insurer that a child is adopted or placed for adoption and to pay the insurer any premium or fees required to provide coverage for the child, within 60 days after coverage is required to begin under sub. (3). If the insured fails to give notice or make payment within 60 days as required by the disability insurance policy in accordance with this subsection, the disability insurance policy shall treat the adopted child or child placed for adoption no less favorably than it treats other dependents, other than newborn children, who seek coverage at a time other than when the dependent was first eligible to apply for coverage.

History: 1989 a. 336; 1995 a. 27 s. 9126 (19); 1995 a. 289; 1997 a. 27; 2007 a. 20 s. 9121 (6) (a); 2007 a. 186; 2009 a. 339.

632.897 Hospital and medical coverage for persons insured under individual and group policies. (1) In this section:

(ac) "Custodial parent" means the parent of a child who has been awarded physical placement with the child for more than 50 percent of the time.

(am) "Dependent" means a person who is or would be covered as a dependent of a group member under the terms of the group policy including, but not limited to, age limits, if the group member continues or had continued as a member of the group.

(b) "Employer" means the policyholder in the case of a group policy as defined in par. (c) 1. or 1m. and the sponsor in the case of a group policy as defined in par. (c) 2. or 3.

(c) "Group policy" means:

1. An insurance policy issued by an insurer to a policyholder on behalf of a group whose members thereby receive hospital or medical coverage on either an expense incurred or service basis, other than for specified diseases or for accidental injuries;

1m. A long–term care insurance policy issued by an insurer to a policyholder on behalf of a group;

2. An uninsured plan or program whereby a health maintenance organization, limited service health organization, preferred provider plan, labor union, religious community or other sponsor contracts to provide hospital or medical coverage to members of a group on either an expense incurred or service basis, other than for specified diseases or for accidental injuries; or

3. A plan or program whereby a sponsor arranges for the mass marketing of franchise insurance to members of a group related to one another through their relationship with the sponsor.

(cm) "Individual policy" means an insurance policy whereby an insured receives hospital or medical coverage on either an expense incurred or service basis, other than for specified diseases or for accidental injuries, and a long–term care insurance policy.

(d) "Insurer" means the insurer in the case of a group policy as defined in par. (c) 1., 1m. or 3. and the sponsor in the case of a group policy as defined in par. (c) 2.

(e) "Medicare" means coverage under both part A and part B of Title XVIII of the federal social security act, 42 USC 1395 et seq., as amended.

(em) "Physical placement" has the meaning given in s. 767.001 (5).

(f) "Terminated insured" means a person entitled to elect continued or conversion coverage under sub. (2) (b) or (9).

(1m) Except as provided in sub. (10), this section applies to any group policy which would otherwise be exempt under s. 600.01 (1) (b) 3. if at least 150 of the certificate holders or insureds are residents of this state.

(2) (a) No group policy which provides coverage to the spouse of the group member may contain a provision for termination of coverage for the spouse solely as a result of a break in their marital relationship except by reason of the entry of a judgment of divorce or annulment of their marriage.

(b) An insurer issuing or renewing a group policy on or after May 14, 1980 and every insurer on and after the date which is 2 years after May 14, 1980 shall permit the following persons who have been continuously covered under a group policy for at least 3 months to elect to continue group policy coverage under sub. (3) or to convert to individual coverage under sub. (4):

1. The former spouse of a group member who otherwise would terminate coverage because of divorce or annulment.

2. A group member who would otherwise terminate eligibility for coverage under the group policy other than a group member who terminates eligibility for coverage due to discharge for misconduct shown in connection with his or her employment.

3. The spouse or dependent of a group member if the group member dies while covered by the group policy and the spouse or dependent was also covered.

(c) Group policy coverage of a terminated insured who is entitled under par. (b) to elect continued group policy coverage or conversion to individual coverage and coverage of the spouse and dependents of the terminated insured provided for in the group policy continues until the terminated insured is notified under par. (d) of the right to elect continued or conversion coverage if the premium for the coverage continues to be paid.

(d) If the employer is notified to terminate the coverage for any of the reasons provided under par. (b), the employer shall provide the terminated insured written notification of the right to continue group coverage or convert to individual coverage and the payment amounts required for either continued or converted coverage including the manner, place and time in which the payments shall be made. This notice shall be given not more than 5 days after the employer receives notice to terminate coverage. The payment amount for continued group coverage may not exceed the group rate in effect for a group member, including an employer's contribution, if any, for a group policy as defined in sub. (1) (c) 1. or 1m. or the equivalent value of the monthly contribution of a group member to a group policy as defined in sub. (1) (c) 2. or the equivalent value of the monthly premium for franchise insurance as defined in sub. (1) (c) 3. The premium for converted coverage shall be determined in accordance with the insurer's table of premium rates applicable to the age and class of risks of each person to be covered under that policy and to the type and amount of coverage provided. The notice may be sent to the terminated insured's home address as shown on the records of the employer.

(3) (a) If the terminated insured or, with respect to a minor, the parent or guardian of the terminated insured, elects to continue group coverage and tenders to the employer the amount required within 30 days after receiving notice under sub. (2) (d), coverage of the terminated insured and, if the terminated insured is eligible for continued coverage under sub. (2) (b) 2., coverage of the covered spouse and dependents of the terminated insured shall continue without interruption and may not terminate unless one of the following occurs:

1. The terminated insured establishes residence outside this state.

2. The terminated insured fails to make timely payment of a required premium amount.

3. The terminated insured is eligible for continued coverage under sub. (2) (b) 1. and the group member through whom the former spouse originally obtained coverage is no longer eligible for coverage by the group policy.

4. The terminated insured becomes eligible for similar coverage under another group policy.

(b) If the coverage of the terminated insured is terminated under par. (a) 3. and the group member through whom the terminated insured originally obtained coverage becomes eligible for coverage by a replacement group policy providing coverage to the same group, the former spouse shall have the right to coverage by the replacement group policy as provided in this subsection.

(c) If the right of the terminated insured to continue group policy coverage is terminated under par. (a) 3. and the group member does not become eligible for coverage by a replacement group policy, the terminated insured has the right to convert to individual coverage under sub. (4), unless sub. (4) (d) applies.

(d) If the right of the terminated insured to continue group policy coverage is terminated under par. (a) 1. the terminated insured, and a spouse or dependent of the terminated insured, if the terminated insured was eligible for continued group coverage under sub. (2) (b) 2. and the spouse or dependent was covered under the group policy, have the right to convert to individual coverage under sub. (4), unless sub. (4) (d) applies.

(e) This subsection does not require coverage of expenses which are covered by medicare.

(4) (a) A terminated insured who elects conversion coverage under sub. (2) (b) or (3) (c) or (d), the spouse or dependent of such a terminated insured, if the terminated insured is eligible under sub. (2) (b) 2. and the spouse or dependent was covered under the group policy, and a terminated insured eligible under sub. (9) and his or her dependents are entitled to have the insurer issue to them, without evidence of insurability, individual coverage reasonably similar to the terminated coverage under the group policy or individual policy. Any probationary or waiting periods required by such individual coverage shall be considered as being met to the extent such limitations have been met under the prior group policy or individual policy.

(b) The commissioner shall promulgate, by rule, 3 plans of individual coverage varying in degree of covered benefits to be

offered as individual conversion policies. The insurer provides reasonably similar individual coverage if a person is offered his or her choice of the plans promulgated by the commissioner or is offered a high limit comprehensive plan of benefits regularly provided by the insurer for conversions and approved for this purpose by the commissioner. This paragraph does not apply if the policy being converted is a long–term care insurance policy.

(bm) The commissioner shall specify, by rule, the minimum standards that an individual conversion policy must satisfy if the policy being converted is a long–term care insurance policy. An insurer provides reasonably similar individual coverage to a person converting a long–term care insurance policy if the person is offered an individual conversion policy that complies with the rules promulgated under this paragraph.

(c) If the first premium for conversion coverage is tendered to the insurer within 30 days after the notice of termination of group coverage, the individual conversion policy shall be issued with an effective date of the day following the termination of group or individual coverage.

(d) This subsection does not require individual coverage to be offered by an insurer offering group policies only. This subsection does not require an insurer to issue an individual conversion policy covering a terminated insured or his or her spouse or dependent if benefits provided or available to the covered person under subds. 1. to 3., together with the converted policy's benefits, would result in overinsurance according to the insurer's standards for overinsurance, and these standards have been filed with and approved by the commissioner prior to use:

1. Similar benefits under another individual policy for which the terminated insured, spouse or dependent is eligible.

2. Similar benefits under a group policy for which the terminated insured, spouse or dependent is eligible.

3. Similar benefits for which the terminated insured, spouse or dependent is eligible by reason of any state or federal law.

(5) A notification of the group continuation and individual conversion privileges shall be included in each certificate of coverage for a group policy as defined in sub. (1) (c) 1., 1m. or 3. and in any evidence of coverage provided by a group policy as defined in sub. (1) (c) 2.

(6) If the terminated insured elects to continue group coverage as provided in this section, the insurer may require conversion to individual coverage by the terminated insured and his or her spouse and dependents 18 months after the terminated insured elects the group coverage except as provided in ss. 103.10 (9) (d) and 103.11 (9) (d). The conditions, rights and procedures governing conversion under sub. (4) (a) apply to this conversion.

(8) Premium payments for continued group coverage required under this section shall be paid to the employer. The employer shall collect, and the insurer shall bill the employer for, those premiums. The insurer shall charge the claims experience of individuals covered under continued group coverage against the claims experience of the employer. An insurer is not required to issue a new certificate of insurance to an individual obtaining continued group coverage under this section.

(9) (a) No individual policy which provides coverage to the spouse of the insured may contain a provision for termination of coverage for the spouse solely as a result of a break in their marital relationship except by reason of the entry of a judgment of divorce or annulment of their marriage.

(b) Every individual policy which contains a provision for the termination of coverage of the spouse of the insured upon divorce or annulment shall contain a provision to the effect that upon divorce or annulment the former spouse has the right to obtain individual coverage under sub. (4) and that coverage of the former spouse shall continue until he or she is notified of that right in accordance with par. (c) if the premium for the coverage continues to be paid by or on behalf of the former spouse. This individual coverage shall provide to the former spouse the option to include dependent children previously covered.

(c) When the insurer is notified that the coverage of a spouse may be terminated because of a divorce or annulment, the insurer shall provide the former spouse written notification of the right to obtain individual coverage under sub. (4), the premium amounts required and the manner, place and time in which premiums may be paid. This notice shall be given not less than 30 days before the former spouse's coverage would otherwise terminate. The premium shall be determined in accordance with the insurer's table of premium rates applicable to the age and class of risk of every person to be covered and to the type and amount of coverage provided. If the former spouse tenders the first monthly premium to the insurer within 30 days after the notice provided by this paragraph, sub. (4) shall apply and the former spouse shall receive individual coverage commencing immediately upon termination of his or her coverage under the insured's policy.

(10) (a) No group policy or individual policy which provides coverage to dependent children of the group member or insured may deny eligibility for coverage to any child, or set a premium for any child which is different from that which is set for other dependent children, based solely on any of the following:

1. The fact that the child does not reside with the group member or insured or is dependent on another parent rather than the group member or insured.

2. The proportion of the child's support provided by the group member or insured.

3. The fact that the group member or insured does not claim the child as an exemption for federal income tax purposes under 26 USC 151 (c), or as an exemption for state income tax purposes under s. 71.07 (8) (b) or under the laws of another state, if a court order under s. 767.513 or the laws of another state assigns responsibility for the child's health care expenses to the group member or insured.

4. The fact that the child is a nonmarital child.

5. The fact that the child resides outside the insurer's geographical service area.

(am) If a court orders an individual to provide coverage for health care expenses for a child of the individual and the individual is eligible for family coverage under a group policy or individual policy, the insurer shall do all of the following:

1. Provide family coverage under the group policy or individual policy for the individual's child, if eligible for coverage, without regard to any enrollment period restrictions that may apply under the policy.

2. Provide family coverage under the group policy or individual policy for the individual's child, if eligible for coverage, upon application by the individual, the child's other parent, the department of children and families or the county child support agency under s. 59.53 (5).

3. After the child is covered under the group policy or individual policy, and as long as the individual is eligible for family coverage under the policy, continue to provide coverage for the child unless the insurer receives satisfactory written evidence that the court order is no longer in effect or that the child has coverage under another group policy or individual policy that provides comparable health care coverage.

(b) Paragraphs (a) and (am) do not prohibit an insurer from determining the eligibility of a group member's or insured's child for coverage under the group policy or individual policy, or the premium for that coverage, based on factors that are not prohibited by par. (a) 1. to 5. and that the insurer applies generally to determine the eligibility of children for coverage, and the premium for coverage, under the group policy or individual policy.

(bf) If an insurer provides coverage under a group policy or an individual policy for a child of a group member or an insured who is not the custodial parent of the child, the insurer shall do all of the following:

1. Provide to the custodial parent of the child information related to the child's enrollment.

2. Permit the custodial parent of the child, a health care provider that provides services to the child or the department of health services to submit claims for covered services without the approval of the parent who is the group member or insured.

3. Pay claims directly to the health care provider, the custodial parent of the child or the department of health services, as appropriate.

(c) This subsection applies to any group policy that would otherwise be exempt under s. 600.01 (1) (b) 3. if at least 25 of the certificate holders or insureds are residents of this state.

(11) (a) Notwithstanding subs. (2) to (10), the commissioner may promulgate rules establishing standards requiring insurers to provide continuation of coverage for any individual covered at any time under a group policy who is a terminated insured or an eligible individual under any federal program that provides for a federal premium subsidy for individuals covered under continuation of coverage under a group policy, including rules governing election or extension of election periods, notice, rates, premiums, premium payment, application of preexisting condition exclusions, election of alternative coverage, and status as an eligible individual, as defined in s. 149.10 (2t), 2011 stats.

(b) The commissioner may promulgate the rules under par. (a) as emergency rules under s. 227.24. Notwithstanding s. 227.24 (1) (c), emergency rules promulgated under this paragraph may remain in effect for one year and may be extended under s. 227.24 (2). Notwithstanding s. 227.24 (1) (a) and (3), the commissioner is not required to provide evidence that promulgating a rule under this paragraph as an emergency rule is necessary for the preservation of the public peace, health, safety, or welfare and is not required to provide a finding of emergency for a rule promulgated under this paragraph.

History: 1979 c. 285, 355; 1981 c. 41; 1983 a. 27, 274; 1985 a. 29; 1987 a. 287, 413; 1989 a. 31; 1993 a. 481; 1995 a. 27 s. 9126 (19); 1995 a. 201; 1997 a. 27, 191, 237; 1999 a. 9; 2005 a. 443 s. 265; 2007 a. 20 ss. 3689, 9121 (6) (a); 2009 a. 342; 2013 a. 20; 2015 a. 345; 2017 a. 366.

Cross–reference: See s. 49.45 (20) concerning exemption from continuation of group coverage.

Cross–reference: See also ss. Ins 3.41, 3.43, 3.44, and 6.51, Wis. adm. code.

The federal employee retirement income security act (ERISA) preempts any state law that relates to employee benefit plans. General Split Corp. v. Mitchell, 523 F. Supp. 427 (1981).

Wisconsin health insurance continuation/conversion law. Michal. WBB Feb. 1982.

632.8985 Prohibiting abortion coverage. (1) In this section, "abortion" has the meaning given in s. 253.10 (2) (a).

(2) A qualified health plan, as defined in 42 USC 18021 (a), that is offered through any American health benefit exchange, as described in 42 USC 18031, that is operating in the state may not cover any abortion the performance of which is ineligible for funding under s. 20.927.

History: 2011 a. 218.

632.899 Medical savings accounts study. If the federal government enacts legislation providing for a federal income tax exemption for amounts deposited in a medical savings account and for any interest, dividends or other gain that accrues in the account if redeposited in the account, the commissioner shall conduct a study, to be completed within 4 years after the enactment of the federal legislation, of individuals and groups that had coverage under a high cost–share health plan, as defined in s. 632.898 (1) (c), 1995 stats., and that terminated that coverage in order to enroll in a health benefit plan that was not a high cost–share health plan, as defined in s. 632.898 (1) (c), 1995 stats. The commissioner shall submit a report of all findings, conclusions and recommendations to the appropriate standing committees in the manner provided under s. 13.172 (3).

History: 1997 a. 27; 2007 a. 96.

SUBCHAPTER VII

FRATERNAL INSURANCE

Cross–reference: See also ch. Ins 1, Wis. adm. code.

632.91 Definition. In this subchapter:

(1) "Insured employee" means an employee of a fraternal or of a subsidiary or other affiliate of a fraternal who is provided insurance benefits by the fraternal under s. 614.10 (2) (c) 2. but is not a member of the fraternal.

(2) "Owner" means the owner of a policy or certificate issued by a fraternal in accordance with s. 614.10.

History: 1989 a. 336; 1991 a. 189; 1997 a. 177.

632.93 The fraternal contract. (1) ISSUANCE OF CERTIFICATE. A fraternal shall issue to each owner a policy or certificate specifying the benefits provided and containing at least in substance all sections of the laws of the fraternal which might result in the termination of coverage or the reduction of benefits. The policy or certificate, any riders or endorsements attached thereto, the laws of the fraternal, and the application and declarations made in connection therewith and signed by the applicant, constitute the agreement between the fraternal and the owner, and the policy or certificate shall so state.

(2) CHANGES IN LAWS OF FRATERNALS. Except as provided in s. 614.24 (1m), any changes in the laws of a fraternal made subsequent to the issuance of a policy or certificate bind the owner and any beneficiary under the policy or certificate as if they had been in force at the time of the application, so long as they do not destroy or diminish benefits promised in the policy or certificate.

(3) PROOF OF TERMS. Copies of any documents mentioned in subs. (1) and (2), certified by the secretary or corresponding officer of the fraternal, are evidence of the terms and conditions of the contract.

(4) INAPPLICABLE PROVISIONS. Sections 631.13 and 632.44 (2) do not apply to fraternal contracts.

(5) GRACE PERIOD. Every fraternal certificate shall contain a provision entitling the owner to a grace period of not less than one month, or 30 days at the fraternal's option, for the payment of any premium due except the first, during which the death benefit shall continue in force. A fraternal may specify in the grace period provision that the overdue premium will be deducted from the death benefit in the event of death before it is paid.

(6) COMPLIANCE WITH OTHER PROVISIONS. If a fraternal's laws provide for expulsion or suspension of a member for any reason other than nonpayment of premium or under s. 632.46, the fraternal's insurance certificate shall contain a provision that if a member is expelled or suspended for any reason other than nonpayment of premium or under s. 632.46, the expelled member, or other owner who was provided insurance benefits under s. 614.10 on the application of the expelled member, has the right to maintain the policy in force by continuing payment of the required premium.

(7) SCOPE OF APPLICATION. This section applies to all contracts made by a fraternal beginning 6 months after December 18, 1979. A fraternal may elect to have this section apply at an earlier date, so long as it applies simultaneously to all such contracts and the fraternal gives the commissioner at least 30 days' notice of intention to adopt this section.

History: 1975 c. 373; 1979 c. 102 ss. 179 to 182, 237; 1987 a. 361; 1989 a. 336; 1997 a. 177.

632.95 Fraud in obtaining membership. Subject to s. 632.46, any certificate of membership secured by misrepresentation in or with reference to any application for membership or documentary or other proof for the purpose of obtaining membership

in or noninsurance benefit from the fraternal is void, if the fraternal relied on it and it is either material or fraudulent.

History: 1975 c. 373.

Legislative Council Note, 1975: This section continues the contractual portion of s. 208.38, edited with a change in meaning, to include nonfraudulent but material misrepresentation, and also to subject the provision to the rule of incontestability provided in s. 632.46. [Bill 643–S]

632.96 Beneficiaries in fraternal contracts. (1) Any owner may designate as beneficiary any person permitted by the laws of the fraternal. Those laws shall authorize the designation of the estate of a member or insured employee as beneficiary.

(2) Subject to sub. (1), s. 632.48 applies.

History: 1975 c. 373, 421; 1989 a. 336; 1997 a. 177.

Legislative Council Note, 1975: Sub. (1) states a rule slightly more restrictive of the range of permitted beneficiaries than for commercial life insurance; this reflects the nature of the fraternal. Sub. (2) applies the general provision for life insurance, subject to sub. (1). [Bill 643–S]

SUBCHAPTER VIII

MISCELLANEOUS

632.97 Application of proceeds of credit insurance policy. Payment to a creditor of any amounts insured under the terms of a credit insurance policy reduces the debt proportionately. This rule does not apply to an insurance policy on which the debtor pays no part of the premium, directly or indirectly.

History: 1975 c. 375.

632.975 Portable electronics insurance. (1) DEFINITIONS. In this section:

(a) "Customer" means a person who purchases or leases a portable electronic device.

(b) "Enrolled customer" means a customer who elects coverage under a portable electronics insurance policy issued to a vendor of portable electronics.

(c) "Location" means any physical location in the state or any Internet site, call center site, or similar location directed to residents of the state.

(d) "Portable electronics" or "portable electronic devices" means electronic devices that are portable in nature, including accessories and services related to the use of the device, and that have an insured value of less than $5,000.

(e) 1. "Portable electronics insurance" means insurance providing coverage for the repair or replacement of portable electronics that may provide coverage for a portable electronic device against any of the following causes of loss:

a. Loss.

b. Theft.

c. Inoperability due to mechanical failure.

d. Malfunction.

e. Damage.

f. Other similar causes of loss.

2. "Portable electronics insurance" does not include any of the following:

a. A service contract or extended warranty providing coverage limited to the repair, replacement, or maintenance of property for the operational or structural failure of property due to a defect in materials, workmanship, accidental damage from handling, power surges, or normal wear and tear.

b. A policy of insurance covering a vendor's or a manufacturer's obligations under a warranty.

c. A homeowner's, renter's, private passenger automobile, commercial multi–peril, or similar insurance policy.

(f) "Portable electronics insurance program" means the coverage options made available to customers of a vendor who elect to enroll for coverage of a portable electronic device under a policy of portable electronics insurance.

(g) "Portable electronics transaction" means the sale or lease of a portable electronic device to a customer.

(h) "Supervising entity" means a business entity that is a licensed insurer or licensed intermediary that is appointed by an insurer to supervise the administration of a portable electronics insurance program offered by a vendor to its customers.

(i) "Vendor" means a person in the business of engaging in portable electronics transactions directly or indirectly.

(2) AUTHORITY. (a) *Requirements.* A vendor or an employee or authorized representative of a vendor may sell or offer portable electronics insurance to customers without holding a certificate of authority under s. 601.04 or a license as an intermediary only if all of the following apply:

1. The vendor complies with the requirements of this section.

2. The insurer issuing the portable electronics insurance either directly supervises, or appoints a supervising entity to supervise, the administration of the sale of portable electronics insurance, including development of a training program, as described under sub. (4), for employees and authorized representatives of the vendors.

3. The supervising entity, if any, maintains a registry of vendor locations at which an employee or authorized representative is authorized to sell or offer portable electronics insurance in this state. Upon request by the commissioner after providing 10 days' notice to the supervising entity, the supervising entity shall make available the registry for inspection and examination by the commissioner.

4. Any employee or authorized representative who intends to sell or offer portable electronics insurance to customers shall complete a training program under sub. (4).

(b) *Prohibited representations.* No employee or authorized representative of a vendor of portable electronics may advertise, represent, or otherwise hold himself or herself out as a licensed insurance intermediary, if the employee or authorized representative does not hold a license as an intermediary in this state.

(c) *Scope.* Compliance by a vendor with this section shall authorize any employee or authorized representative of a vendor to sell or offer coverage under a policy of portable electronics insurance to a customer at each location at which the vendor engages in portable electronics transactions.

(d) *Applicability of existing law.* A vendor selling or offering portable electronics insurance is subject to ss. 601.41, 601.42, 601.61, 601.63, and 601.64, except that any forfeitures or penalties shall be in the amounts specified in sub. (3). Sections 424.301 and 424.401 do not apply to portable electronics insurance.

(3) PENALTIES. If a vendor of portable electronics or an employee or authorized representative of a vendor violates any provision of this section, the commissioner may do any of the following:

(a) After notice and hearing conducted in accordance with s. 601.62, impose forfeitures not to exceed $500 per violation.

(b) Order, under s. 601.41 (4), any of the following:

1. Suspension of the selling or offering of portable electronics insurance at the specific business location where the violation occurred.

2. Suspension of the selling or offering of portable electronics insurance by an employee or authorized representative of a vendor.

3. Suspension or revocation of the selling or offering of portable electronics insurance by a vendor in this state.

(4) TRAINING. The insurer or supervising entity shall develop and administer the training program required under sub. (2) (a) 4. that complies with all of the following:

(a) The insurer or supervising entity shall deliver training to employees and authorized representatives of a vendor who are

directly engaged in selling or offering portable electronics insurance.

(b) The insurer or supervising entity may provide the training in electronic form. If the training is in electronic form, the insurer or supervising entity shall implement a supplemental education program regarding portable electronics insurance that is conducted and overseen by licensed employees of the insurer or supervising entity.

(c) The insurer or supervising entity shall provide to every employee and authorized representative of a vendor basic instruction about the portable electronics insurance offered to customers and the disclosures required under sub. (6).

(5) COMPENSATION. (a) A vendor of portable electronics may not compensate an employee or authorized representative based primarily on the number of customers enrolled in portable electronics insurance coverage but the vendor may compensate an employee or authorized representative, in a manner that is incidental to his or her overall compensation, for activities related to the sale or offering of portable electronics insurance.

(b) 1. A vendor of portable electronics may bill and collect the charges for portable electronics insurance coverage.

2. The vendor shall separately itemize on the enrolled customer's bill any charge to the enrolled customer for coverage that is not included in the cost associated with the purchase or lease of the portable electronics.

3. If the portable electronics insurance coverage is included with the purchase or lease of a portable electronic device, the vendor shall clearly and conspicuously disclose to the enrolled customer that the coverage is included with the purchase or lease of the portable electronic device.

4. A vendor that bills and collects charges from an enrolled customer is not required to maintain those moneys in a segregated account if the insurer authorizes the vendor to hold those moneys in a manner other than a segregated account and if the vendor remits the moneys to the insurer or supervising entity within 60 days of receiving those moneys. The vendor shall consider all moneys received by that vendor from an enrolled customer for the sale of portable electronics insurance to be held in trust by that vendor in a fiduciary capacity for the benefit of the insurer.

5. The insurer or supervising entity may compensate the vendor for billing and collection services.

(6) DISCLOSURES. At every location where portable electronics insurance is offered to customers, a vendor shall make available to prospective customers brochures or other written materials that contain all of the following:

(a) A disclosure that portable electronics insurance may provide a duplication of coverage already provided by a customer's homeowner's insurance policy, renter's insurance policy, or other source of insurance coverage.

(b) A statement that a customer is not required to enroll in portable electronics insurance as a condition of purchasing or leasing a portable electronic device.

(c) A summary of the material terms of the portable electronics insurance coverage including all of the following:

1. The identity of the insurer.

2. The identity of the supervising entity, if any.

3. The amount of any applicable deductible and how to pay that deductible.

4. The benefits of coverage.

5. The key terms and conditions of coverage such as whether a portable electronic device covered under the policy may be repaired or replaced with parts or equipment of a similar make and model that are reconditioned or are nonoriginal manufacturer parts or equipment.

(d) A summary of the process for filing a claim, including a description of how to return a portable electronic device and the maximum fee applicable in the event the enrolled customer fails to comply with any equipment return requirement.

(e) A statement that the enrolled customer may cancel enrollment for coverage under a portable electronics insurance policy at any time and that upon cancellation the person paying the premium receives a refund of any applicable unearned premium.

(7) PERMITTED OFFERING. A vendor may offer portable electronics insurance on a month to month or other periodic basis as a group or master commercial inland marine policy that is issued to a vendor of portable electronics for its enrolled customers.

(8) UNDERWRITING. An insurer shall establish eligibility and underwriting standards for customers electing to enroll in coverage for each portable electronics insurance program offered by a vendor to its customers.

(9) TERMINATION OF INSURANCE; CHANGES TO POLICY. (a) Except as provided in par. (c), an insurer may terminate or otherwise change the terms and conditions of a policy of portable electronics insurance only after providing the policyholder and all enrolled customers at least 30 days' notice before terminating the coverage or making the change.

(b) If the insurer changes the terms and conditions in accordance with par. (a), the insurer shall provide the vendor policyholder with a revised policy or endorsement and shall provide each enrolled customer a revised certificate, endorsement, updated brochure, or other evidence indicating that a change in the terms and conditions has occurred and a summary of the material changes.

(c) 1. An insurer may terminate the enrollment of an enrolled customer under a portable electronics insurance policy after providing 15 days' notice if the insurer discovers that the enrolled customer committed fraud or made a material misrepresentation in obtaining coverage or in the presentation of a claim under the portable electronics insurance policy.

2. An insurer may immediately terminate the enrollment of an enrolled customer under a portable electronics insurance policy for any of the following reasons:

a. The enrolled customer fails to pay the premium for the portable electronics insurance policy.

b. The enrolled customer ceases to have an active service with the vendor of portable electronics.

3. An insurer may terminate the enrollment of an enrolled customer under a portable electronics insurance policy if the enrolled customer exhausts any aggregate limit of liability under the terms of the portable electronics insurance policy and the insurer sends notice of termination to the enrolled customer within 30 days after exhaustion of the limit. If the insurer does not send the notice within 30 days after exhaustion of the limit, the insurer shall continue the coverage notwithstanding the aggregate limit of liability until the insurer sends notice of termination to the enrolled customer.

(d) If a portable electronics insurance policy is terminated by a vendor that owns the policy, the vendor shall mail or deliver, at least 30 days before the termination, written notice to each enrolled customer advising of the termination of the portable electronics insurance policy and the effective date of termination.

(e) Any notice or correspondence with respect to coverage under a policy of portable electronics insurance that is required under this section or is otherwise required by law shall be in writing and may be mailed to the vendor at the mailing address of the vendor and to the enrolled customers at their last known mailing addresses on file with the insurer or delivered by electronic means to the vendor and enrolled customers. If the notice or correspondence is mailed, the insurer, or vendor, that mailed the notice or correspondence, shall maintain proof of mailing in a form authorized or accepted by the U.S. postal service or other commercial mail delivery service. If delivery of the notice or correspondence is by electronic means, the insurer shall use the electronic mail address specified by the vendor for that purpose and the insurer, or vendor, shall use the last known electronic mail address provided by each enrolled customer. An enrolled customer who provides an electronic mail address to the insurer or

vendor consents to receive notices and correspondence by electronic means. If delivery is by electronic means, the insurer or vendor, whichever delivers the notice or correspondence, shall maintain proof of delivery.

(f) A supervising entity may send any notice or correspondence required by this section or otherwise required by law. An insurer or vendor is not required to provide the notice or correspondence if it is provided by a supervising entity in a manner that complies with this section.

History: 2011 a. 225; 2013 a. 165 s. 115; 2013 a. 230.

632.977 Limited lines travel insurance. (1) DEFINITIONS. In this section:

(a) "Firm" means a firm under s. Ins 6.58 (1m), Wis. Adm. Code, that sells, solicits, or negotiates travel insurance through an individual travel insurance producer.

(ac) "Firm license" means a license described in s. Ins 6.58 (2), Wis. Adm. Code, that is held by a firm.

(am) "Offer and disseminate" means to provide general information, including a description of coverage and price, as well as to process applications, collect premiums, and perform other activities permitted by statute or rule.

(b) 1. "Travel insurance" means limited lines insurance coverage for personal risks incident to planned travel, including any of the following:

a. Interruption or cancellation of trip or event.

b. Loss of baggage or personal effects.

c. Damages to accommodations or rental vehicles.

d. Sickness, accident, disability, or death occurring during travel.

2. "Travel insurance" does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting 6 months or longer, such as those persons working overseas as expatriates or military personnel being deployed.

(c) "Travel insurance producer" means an intermediary who is licensed under sub. (2) to sell, solicit, or negotiate travel insurance.

(d) "Travel retailer" means a business entity that makes, arranges, or offers travel services.

(2) LIMITED LICENSE TO SELL TRAVEL INSURANCE. The commissioner may issue to a person licensed as an intermediary under ch. 628 who applies on a form and in the manner prescribed by the commissioner, a limited lines travel insurance producer license authorizing the person to sell, solicit, or negotiate travel insurance through an insurer.

(3) AUTHORITY TO OFFER AND DISSEMINATE TRAVEL INSURANCE. A travel retailer, or an employee or authorized representative of a travel retailer, may offer and disseminate travel insurance under a firm license of a firm, only if the firm holds such a license, and only if all of the following apply:

(a) A travel insurance producer or the travel retailer provides to purchasers of travel insurance all of the following:

1. The material terms, or a description of the material terms, of the travel insurance coverage.

2. A description of the process for filing a claim.

3. A description of the review or cancellation process for the travel insurance policy.

4. The identity and contact information of the firm.

(b) The firm keeps a register of each travel retailer that offers and disseminates travel insurance on the firm's behalf. The register shall include the name and contact information of the travel retailer and of an officer or person who directs or controls the travel retailer's operations and the travel retailer's federal tax identification number. The firm shall also certify that the travel retailer register complies with 18 USC 1033. The firm shall submit the register to the commissioner upon request within 30 days after receiving a request.

(c) The firm has designated a travel insurance producer responsible for ensuring the travel retailer's compliance with the limited lines travel insurance statutes and rules of this state.

(d) The firm has paid all applicable licensing fees under s. 601.31 (1) (L) 2.

(e) A travel insurance producer requires each employee and authorized representative of the travel retailer whose duties include offering and disseminating travel insurance to receive a program of instruction or training, which shall be subject to review by the commissioner. The instruction or training materials shall contain, at a minimum, instructions on the types of insurance offered, ethical sales practices, and required disclosures to prospective customers.

(4) TRAVEL RETAILER DUTIES, LIMITATIONS, RIGHT TO COMPENSATION. (a) A travel retailer that offers and disseminates travel insurance on behalf of and under the control of a travel insurance producer shall make available to prospective purchasers of the travel insurance, brochures or other written materials that do all of the following:

1. Provide the identity and contact information of the insurer and the travel insurance producer.

2. Explain that the purchase of travel insurance is not required for the purchase of any other product or service from the travel retailer.

3. Explain that a travel retailer that is not licensed as a travel insurance producer may provide general information about the insurance offered by the travel retailer, including a description of the coverage and price, but is not qualified or authorized to answer technical questions about the terms and conditions of the insurance offered by the travel retailer or to evaluate the adequacy of the customer's existing insurance coverage.

(b) A travel retailer's employee, or authorized representative, who is not licensed as a travel insurance producer may not do any of the following:

1. Evaluate or interpret technical terms, benefits, or conditions of the offered travel insurance coverage.

2. Evaluate or provide advice concerning a prospective purchaser's existing insurance coverage.

3. Hold himself or herself out as an insurer, a licensed travel insurance producer, or an insurance expert.

(c) A travel retailer whose insurance–related activities, and those of its employees and authorized representatives, are limited to offering and disseminating travel insurance on behalf of and under the direction of a travel insurance producer that meets the conditions under this section is authorized to do so and to receive related compensation upon registration by the firm under sub. (3) (b).

(5) MISCELLANEOUS PROVISIONS. (a) Travel insurance may be provided under an individual policy or under a group or master policy.

(b) As the insurer designee, a travel insurance producer is responsible for the acts of each travel retailer offering and disseminating travel insurance on its behalf and under its control and shall use reasonable means to ensure compliance by the travel retailer with this section.

(c) A travel retailer offering and disseminating travel insurance on behalf of and under the control of a travel insurance producer and a travel insurance producer are exempt from the examination and education requirements under s. 628.04 (3).

(d) A travel insurance producer and any travel retailer offering and disseminating travel insurance on behalf of and under the control of a travel insurance producer are subject to ss. 601.41 (4), 601.43, 601.44, 601.61 to 601.64, and 628.34.

History: 2013 a. 212.

632.98 Worker's compensation insurance. Sections 102.31, 102.315, and 102.62 apply to worker's compensation insurance.

History: 1975 c. 375, 421; 1979 c. 102; 2007 a. 185.

632.99 Certifications of disability. For the purpose of insurance policies that they issue, every insurer doing a health or disability insurance business in this state shall afford equal weight to a certification of disability signed by a physician with respect to matters within the scope of the physician's professional license, to a certification of disability signed by a chiropractor with respect to matters within the scope of the chiropractor's professional license, and to a certification of disability signed by a podiatrist with respect to matters within the scope of the podiatrist's professional license. This section does not require an insurer to treat any certification of disability as conclusive evidence of disability.

History: 1981 c. 55; 2009 a. 113.