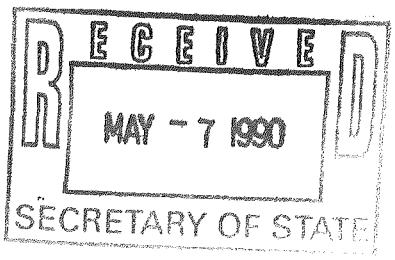
CR 90-060



STATE OF WISCONSIN)
)
OFFICE OF THE COMMISSIONER OF INSURANCE)

TO ALL TO WHOM THESE PRESENTS SHALL COME, GREETINGS:

I, Robert D. Haase, Commissioner of Insurance and custodian of the official records of said Office, do hereby certify that the annexed order repealing, renumbering, amending, recreating, and creating a rule relating to standards for disability insurance sold to Medicare eligible was issued by this Office on May 7, 1990.

I further certify that said copy has been compared by me with the original on file in this Office and that the same is a true copy thereof, and of the whole of such original.

IN TESTIMONY WHEREOF, I have hereunto subscribed my name in the City of Madison, State of Wisconsin, this 7th day of May 1990.

Robert D. Haase
Commissioner of Insurance

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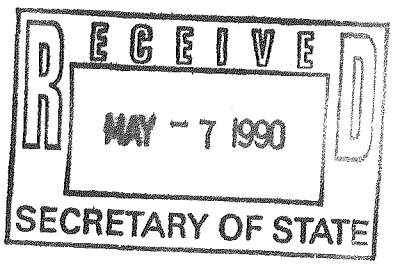

ORDER OF THE COMMISSIONER OF INSURANCE

AMENDING A RULE

The Commissioner of Insurance orders the following:

a. Repeal: Ins 3.39 (5) (d), (e), (f), (g), and (h), Ins 3.39 (8) (d); Ins 25.03, Ins 25.04, Ins 25.05, Ins 25 Apendices 1 to 6

b. Renumber: Ins 3.39 (3) (a)

c. Amend: Ins 3.39 (2) (a) 3, Ins 3.39 (4) (a) 2 and 3, Ins 3.39 (4) (a) 7, Ins 3.39 (4) (b) 5, Ins 3.39 (4) (d), Ins 3.39 (4) (e) 1, Ins 3.39 (4) (e) 5, Ins 3.39 (4) (g), Ins 3.39 (5) (b), (c) (intro.), 2, 4 and 5, Ins 3.39 (5) (i) 4 and 5, Ins 3.39 (6) (intro.) and (b), Ins 3.39 (7) (c) 4 and 5, Ins 3.39 (8) (a) 1, Ins 3.39 (8) (e), Ins 3.39 (9) (e), Ins 3.39 (10) (a) (intro.), Ins 3.39 (10) (d) 2, Ins 3.39 (11), Ins 3.39 (14)

d. Repeal and recreate: Ins 3.39 (4) (b) 7, Ins 3.39 Appendix

e. Create: Ins 3.39 (3) (a), Ins 3.39 (4) (a) 14, Ins 3.39 (4) (f), Ins 3.39 (5) (c) 6, 7, 8, 9, and to 12, Ins 3.39 (5) (i) 7, Ins 3.39 (7) (c) 6, 7, 8, and (d), Ins 3.39 (15) to (28), and Ins 3.39 Appendices 2, 3, 4, 5, and 6

582R2
03/30/90

ANALYSIS PREPARED BY THE COMMISSIONER OF INSURANCE

This rule amends the requirements of medicare supplement policies sold in the state of Wisconsin. The changes include technical changes required to obtain the approval of the Wisconsin medicare supplement rule by supplemental health insurance panel is required by the Omnibus Budget Reconciliation Act of 1987. A brief description of the changes follows.

Technical changes are made in the definitions. A provision is added to clearly limit the waiting period for preexisting conditions to no more than six months. The benefits page of a medicare supplement policy is required to include both the modal premium selected by the applicant and the annualized premium. This is to provide a basis of comparison. Previously, many companies were showing only the modal premium and comparison with other policies which showed an annual premium was more difficult.

The basis for computing loss ratios is changed to specifically include actual and anticipated as the current rule which only references anticipated incurred claims. Any use of the terms medicare supplement, Medigap, or other similar terms is prohibited as it is required by the federal panel. The requirements in sub. (5) (c) 2, 4, and 5, are amended to account for the repeal of the Medicare Catastrophic Act. In addition, SECTIONS 6, 7, 8, 9, and 10 were added. The requirements for the foreign travel rider are specifically stated as requiring certain minimum benefits.

Because of the repeal of the Medicare Catastrophic Act there is very limited coverage under Medicare for drug benefits and the prescription drug usual and customary charges rider minimum benefits had to be revised to reflect the limited Medicare drug benefit. Requirements for group medicare supplement policies are amended in SECTION 7 to be made appropriate with the repeal of Medicare Catastrophic Act.

582R3
03/30/90

SECTION 15 is created to clearly define who must file advertisements. There is a differentiation made between insurer's advertisements and agent's advertisements and a new requirement that agents file advertisements. This section is moved from the current Ins 25. In SECTION 16 specific requirements for loss ratios are spelled out including how they are to be calculated. SECTION 17 sets forth the requirements for policies which were sold prior to the repeal of the Medicare Catastrophic Act. In addition, SECTION 18 lays out notice requirements to these insureds. SECTION 19 details the requirements for forms and rate reviews for existing medicare supplement policies. SECTION 20 is the requirement of the repealed legislation. It requires that insureds who terminated medicare supplement policies in 1989 and have not obtained replacement coverage be offered reinstatement of their original policy by the insurer. SECTION 21 is a requirement of the NAIC model which limits the commissions payable to agents on medicare supplement policies. The notices required in replacement situations have been changed to specifically apply to medicare supplements as opposed to a generalized notice for all health insurance sold. SECTION 24 requires insurers to set up standards for marketing to assure that comparison by its agents or other producers will be accurate. Various other new NAIC Medicare Rule model requirements are set forth in SECTIONS 26 through 28. The appendices are revisions of forms currently required and specifically referenced in the body of the rule.

Pursuant to the authority invested in the Office of the Commissioner of Insurance by ss. 601.41 (3), 628.34 (12), and 632.81, Stats., the Office of the Commissioner of Insurance amends a rule as follows:

SECTION 1. Ins 3.39 (2) (a) 3 is amended to read:

3. Any individual or group policy sold predominantly in Wisconsin to the Medicare eligible by reason of age which offers hospital, medical, surgical, or other disability coverage, except for a policy which offers solely nursing home, hospital confinement indemnity, or specified disease coverage; and

SECTION 2. Ins 3.39 (3) (a) is renumbered Ins 3.39 (3) (am).

SECTION 3. Ins 3.39 (3) (a) is created to read:

(a) "Advertisement" has the meaning set forth in s. Ins 3.27 (5) (a).

SECTION 4. Ins 3.39 (4) (a) 2 and 3 are amended to read:

2. Discloses on the first page any applicable preexisting condition limitation, contains no preexisting condition waiting period longer than 6 months, and does not define a preexisting condition more restrictively than a condition for which medical advice or treatment was recommended by or received from a physician within 6 months before the effective date of coverage;

3. Contains no definitions of terms such as "skilled nursing facility", "hospital", "nurse", "physician", "Medicare approved expenses", "benefit period", or "outpatient prescription drugs" which are worded less favorably to the insured person than the corresponding Medicare definition, and ~~contains as a definition of the term,~~ defines "Medicare"~~,~~ as Title XVIII of the Federal ~~Social Security Act~~ social security act of 1965 as Amended";

SECTION 5. Ins 3.39 (4) (a) 7 is amended to read:

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

SECTION 6. Ins 3.39 (4) (a) 14 is created to read:

14. Contains no exclusion, limitation, or reduction of coverage for a specifically named or described condition for longer than 6 months after the policy effective date.

SECTION 7. Ins 3.39 (4) (b) 5 is amended to read:

5. Is substantially in the format prescribed in ~~the~~ appendix 1 to this section for the appropriate category;

SECTION 8. Ins 3.39 (4) (b) 7 is repealed and recreated to read:

7. Contains a listing of the required coverage as set out in sub. (5) (c), (e), and (g), and the optional coverages as set out in sub. (5) (d), (f), (h), and (i), and the annual premiums therefor, substantially in the format of sub. (11) of appendix 1; and

SECTION 9. Ins 3.39 (4) (d) is amended to read:

(d) The schedule of benefits page or the first page of the policy or certificate ~~shall contain~~ contains a listing giving the ~~coverage~~ coverages ~~designation~~ and both the annual premium ~~rate~~ in the format shown in sub. (11)

of Appendix 1 and modal premium selected by the applicant ~~in the format shown in sub. (10) of the Appendix~~.

SECTION 10. Ins 3.39 (4) (e) 1 is amended to read:

(e) 1. Is computed on the basis of anticipated incurred claims and earned premiums ~~as estimated~~ for the entire period for which the policy form ~~will provide~~ provides coverage, in accordance with accepted actuarial principles and practices;

SECTION 11. Ins 3.39 (4) (e) 5 is amended to read:

5. Is ~~approved by~~ submitted to the commissioner along with the policy form.

SECTION 12. Ins 3.39 (4) (f) is created to read:

(f) Except as otherwise provided in this subsection, the terms "medicare supplement", "medigap" and words of similar import may not be used in a policy or in any advertisement or sales presentation for a policy unless the policy conforms to sub. (5) or (7).

SECTION 13. Ins 3.39 (4) (g) is amended to read:

(g) As regards subsequent rate changes to the policy form, the insurer ~~shall~~:

1. Files such changes on a rate change transmittal form in a format specified by the commissioner ~~substantially identical to Appendix 4 of Ins 25~~.

2. ~~Include~~ Includes in its filing an actuarially sound demonstration that the rate change will not result in a loss ratio over the life of the policy which would violate sub. (4) (e).

SECTION 14. Ins 3.39 (5) (b) and (c) (intro.), 2, 4 and 5 are amended to read:

(b) The caption, except that the word "certificate" may be used instead of "policy", if appropriate: "The Wisconsin Insurance Commissioner has set standards for Medicare supplement insurance. This policy meets these standards. It, along with Medicare, may not cover all of your medical costs. You should review carefully all policy limitations. For an explanation of these standards and other important information, see 'Health Insurance Advice for Senior Citizens,' given to you when you applied for this policy. Do not buy this policy if you did not get this guide."

(c) The following required coverages, to be referred to as "Basic Medicare Supplement coverage" for ~~policies~~ a policy issued after December 31, 1989:

2. Medicare Part A eligible expenses in a skilled nursing facility to the extent not covered by Medicare subject to a maximum benefit of 265 days per ~~calendar-year-of-365-days~~ benefit period,

4. All Medicare Part B approved expenses to extent not paid by Medicare, including outpatient psychiatric care, subject to the Medicare Part B calendar year deductible ~~and-to-a-policy-maximum-calendar-year-benefit of-at-least-$10,000;-and~~;

5. Home care benefits to a minimum of 40 visits per 12-month period as required under s. 632.895 (1) and (2), Stats., and s. Ins 3.54~~.~~;

SECTION 15. Ins 3.39 (5) (c) 6 to 10 are created to read:

6. Nursing home confinement, kidney disease treatment, and diabetes expense coverage as required under s. 632.895 (3), (4) and (6), Stats.;

7. In group policies, nervous and mental disorder and alcoholism and other drug abuse coverage as required under s. 632.89, Stats.;

8. Chiropractic coverage as required under s. 632.87, Stats.;

9. Coverage for the first 3 pints of blood payable under Part B.

10. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

11. Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

12. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of all Medicare Part A eligible expenses for hospitalization not covered by Medicare.

SECTION 16. Ins 3.39 (5) (d) to (h) are repealed.

SECTION 17. Ins 3.39 (5) (i) 4 and 5 are amended to read:

4. Coverage for the difference between Medicare's Part B approved charges and the usual, customary and reasonable charges as determined by the insurer. ~~This coverage may be applied to the calendar year policy maximum for Medicare Part B expenses if expressly stated.~~ If included as a rider, the rider shall be designated as: MEDICARE PART B USUAL AND CUSTOMARY CHARGES RIDER;

5. Coverage for benefits obtained outside the United States. An insurer which offers this benefit shall not limit coverage to medicare deductibles and copayments. Coverage may contain a deductible of up to $250. Coverage shall pay at least 80% of reasonable charges. The benefit period must be at least 30 days per year. If included as a rider, the rider shall be designated as: FOREIGN TRAVEL RIDER.

SECTION 18. Ins 3.39 (5) (i) 7, is created to read:

7. At least 75% of the usual and customary changes for outpatient prescription drugs after a deductible of no greater than $100 per year. If issued as a rider, the rider shall be designated as: OUTPATIENT PRESCRIPTION DRUG USUAL AND CUSTOMARY CHARGES RIDER.

SECTION 19. Ins 3.39 (6) (intro.) and (b) are amended to read:

(6) USUAL, CUSTOMARY AND REASONABLE CHARGES. If an insurer includes a policy provision limiting benefits to the usual, customary and reasonable charge as determined by the insurer, ~~(UCR),~~ the insurer shall:

(b) Have ~~written~~ reasonable written standards based on similar services rendered in the locality of the provider to support ~~claims~~ benefit determination which shall be made available to the commissioner on request.

SECTION 20. Ins 3.39 (7) (c) 4 and 5 are amended to read:

4. The Medicare Part B deductible and all Medicare Part B approved expenses, including outpatient psychiatric care, to the extent not covered by Medicare; ~~and~~

5. Home care benefits of 40 visits per 12-month period as required under s. 632.895 (1) and (2), Stats., and s. Ins 3.54~~.~~;

SECTION 21. Ins 3.39 (7) (c) 6 to 8, and (d) are created to read:

6. Nursing home confinement, kidney disease treatment, and diabetes expense coverage as required under s. 632.895 (3), (4) and (6), Stats.;

7. In group policies, nervous and mental disorder and alcoholism and other drug abuse coverage as required under s. 632.89, Stats.; and

8. Chiropractic coverage as required under s. 632.87, Stats.

(d) The availability of an approved medicare supplement insurance policy. Each insurer which markets a medicare replacement policy shall have an approved medicare supplement insurance policy available for all currently enrolled participants at such time as the direct risk contract between the Health Care Financing Administration and the insurer is terminated.

SECTION 22. Ins 3.39 (8) (a) 1 is amended to read:

1. ~~Exclude~~ May exclude expenses for which the insured is compensated by Medicare;

SECTION 23. Ins 3.39 (8) (d) is repealed.

SECTION 24. Ins 3.39 (8) (e) is amended to read:

(e) A medicare replacement policy and a medicare supplement policy may include other ~~policy~~ exclusions and limitations which are not otherwise prohibited and are not more restrictive than exclusions and limitations contained in Medicare.

SECTION 25. Ins 3.39 (9) (e) is amended to read:

(e) Other coverage. An individual disability policy sold to a Medicare eligible person, other than a form subject to subs. (5) ~~and~~ or (7) or otherwise subject to the caption requirements in this subsection or exempted by sub. (2) (d) or (e), shall bear the caption: "This policy is not a medicare supplement. For more information, see 'Health Insurance Advice for Senior Citizens', given to you when you applied for this policy."

SECTION 26. Ins 3.39 (10) (a) (intro.) is amended to read:

(a) Conversion requirements. An insured under individual, family, or group hospital or medical coverage who will become eligible for Medicare and is offered a conversion policy which is not subject to subs. (4)~~,~~ and (5)~~,-and~~ or (7) shall be furnished by the insurer, at the time the conversion application is furnished in the case of individual or family coverage or within 14 days of a request in the case of group coverage:

SECTION 27. Ins 3.39 (10) (d) 2 is amended to read:

2. For a conversion policy not subject to subd. 1., shall comply with sub. ~~(10)~~(9), where applicable, and s. Ins 3.27 (5) (1).

SECTION 28. Ins 3.39 (11) is amended to read:

(11) "HEALTH INSURANCE ADVICE FOR SENIOR CITIZENS" PAMPHLET. Every prospective Medicare eligible purchaser of any policy or certificate subject to this section which provides hospital or medical coverage, other than incidentally, or of any coverage added to an existing medicare supplement policy or certificate shall receive a copy of the current edition of the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" at the time the prospect is contacted by an intermediary or insurer with an invitation to apply as defined in s. Ins 3.27 (5) (g). Except in the case of direct response insurance, written acknowledgement of receipt of this pamphlet shall be obtained by the insurer. This pamphlet ~~prepared-by-the-office-of-the commissioner-of-insurance~~ provides information on Medicare and advice to senior citizens on the purchase of medicare supplement insurance and other health insurance. Insurers may obtain information from the commissioner's office on how to obtain copies or may reproduce this pamphlet themselves.

This pamphlet ~~shall~~ may be periodically revised to reflect changes in Medicare and any other appropriate changes. No insurer shall be responsible for providing applicants the revised pamphlet until 30 days after the insurer has been given notice that the revised pamphlet is available.

SECTION 29. Ins 3.39 (14) is amended to read:

(14) OTHER REQUIREMENTS. Insurers issuing medicare supplement policies shall comply with all provisions of Section 4081 of the Omnibus Budget Reconciliation Act of 1987 and shall annually certify on the Medicare Supplement Experience Exhibit that it has complied with these requirements.

SECTION 30. Ins 3.39 (15) to (28) are created to read:

(15) FILING REQUIREMENTS FOR ADVERTISING. Prior to use in this state, every insurer shall file with the commissioner a copy of any advertisement used in connection with the sale of medicare supplement policies issued with an effective date after December 31, 1989. If the advertisement does not reference a particular insurer or medicare supplement policy, each agent utilizing the advertisement shall file the advertisement with the commissioner prior to using it. Insurers and agents shall submit the advertisements using forms specified in Appendices 2 and 3. The advertisements shall comply with all applicable laws and rules of this state.

(16) LOSS RATIO REQUIREMENTS FOR EXISTING POLICIES. (a) Every insurer providing medicare supplement policies in this state shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by number of years of policy duration demonstrating that it is in compliance with the applicable loss ratio standards contained in sub. (4) (e) and that the period for which the policy

is rated is reasonable in accordance with accepted actuarial principles and experience.

(b) For the purposes of this section, policy forms shall be deemed to comply with the loss ratio standards if:

1. For the most recent year, the ratio of the incurred losses to earned premiums for policies or certificates which have been in force for three years or more is greater than or equal to the applicable percentages contained in sub. (4) (e); and

2. The expected losses in relation to premiums over the entire period for which the policy is rated comply with the requirements of sub. (4) (e). An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three years.

(c) As soon as practicable, but no later than October 1 of the year prior to the effective date of Medicare benefit changes, every insurer providing medicare supplement insurance or contracts in this state shall file with the commissioner in accordance with the applicable filing procedures of this state:

1. a. Appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the applicable policies or contracts. Supporting documents as necessary to justify the adjustment shall accompany the filing.

b. Every insurer providing medicare supplement insurance or benefits to a resident of this state shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or contract as will conform with minimum loss ratio standards for medicare supplement policies and which are expected to result in a loss ratio at least as great as

that originally anticipated in the rates used to produce current premiums by the insurer for such medicare supplement insurance policies or contracts. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein should be made with respect to a policy at any time other than upon its renewal date or anniversary date. Premiums adjustments shall be in the form of refunds or premium credits and shall be made no later than upon renewal if a credit is given, or within sixty (60) days of the renewal date or anniversary date if a refund is provided to the premium payer. Premium adjustments shall be calculated for the period commencing with Medicare benefit changes.

2. Any appropriate riders, endorsements or policy forms needed to accomplish the medicare supplement insurance modifications necessary to eliminate benefit duplications with Medicare. Any riders, endorsements or policy forms shall provide a clear description of the medicare supplement benefits provided by the policy or contract.

(17) BENEFIT CONVERSION REQUIREMENTS DURING TRANSITION.

(a) Effective January 1, 1990, no medicare supplement insurance policy, contract or certificate in force in this state shall contain benefits which duplicate benefits provided by Medicare.

(b) Benefits eliminated by operation of the Medicare Catastrophic Coverage Act of 1988 transition provisions shall be restored.

(c) For medicare supplement policies subject to the minimum standards adopted pursuant to Medicare Catastrophic Coverage Act for 1988, the minimum benefits shall be no less than those specified in sub. (5) (c).

(18) NOTICE REQUIREMENTS TO EXISTING POLICYHOLDERS.

(a) No later than January 31, 1990, every insurer providing medicare supplement insurance or benefits to a resident of this state shall notify its

policyholders, contract holders and certificateholders of modifications it has made to its medicare supplement insurance policies or contracts. Such notice shall be in the format shown in Appendix 4 and shall:

1. Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the medicare supplement insurance policy or contract.

2. Inform each covered person as to when any premium adjustment due to changes in Medicare benefits will be effective.

3. Be in outline form and in clear and simple terms so as to facilitate comprehension for the notice of benefit modifications and any premium adjustments.

4. Not contain or be accompanied by any solicitation.

(b) No modifications to an existing medicare supplement contract or policy shall be made at the time of or in connection with the notice requirements of this regulation except to the extent necessary to accomplish the purposes articulated in this subsection.

(19) FORM AND RATE FILING REQUIREMENTS FOR EXISTING POLICYHOLDERS.

(a) Every insurer providing medicare supplement insurance or contracts in this state shall file with the commissioner, in accordance with the applicable filing procedures of this state:

1. Appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the applicable policies or contracts. Such supporting documents as necessary to justify the adjustment shall accompany the filing prior to January 31, 1990.

2. Any appropriate riders, endorsements or policy forms needed to accomplish the medicare supplement insurance modifications necessary to eliminate benefit duplications with Medicare and to provide the benefits

required by this section prior to January 15, 1990. Any such riders, endorsements or policy forms shall provide a clear description of the medicare supplement benefits provided by the policy or contract.

(b) Upon satisfying the filing and approval requirements of this state, every insurer providing medicare supplement insurance in this state shall provide each covered person with any rider, endorsement or policy form necessary to make the adjustments outlined in sub. (18).

(c) Any premium adjustments shall produce an expected loss ratio under such policy or contract as will conform with the minimum loss ratio standards for medicare supplement policies and shall result in an expected loss ratio at least as great as that originally anticipated by the insurer, health care service plan or other entity for such medicare supplement insurance policies or contracts. Premium adjustments may be calculated for the period commencing with the Medicare benefit changes.

(d) Insurers may adjust the premium charged to policies referenced in pars. (a), (b) and (c) retroactive to January 1, 1990, providing the insurer files the proposed rate change with the commissioner prior to January 30, 1990, and notifies the insured in writing no later than January 31, 1990.

(20) OFFER OF REINSTITUTION OF COVERAGE.

(a) Except as provided in par. (b), in the case of an individual who had in effect, as of December 31, 1988, a medicare supplemental policy with an insurer (as a policyholder or, in the case of a group policy, as a certificateholder) and the individual terminated coverage under such policy before January 1, 1990, the insurer shall:

1. Provide written notice no later than January 30, 1990, to the policyholder or certificateholder at the most recent available address of the offer described in subd. 2., and

2. Offer the individual, prior to April 1, 1990, reinstitution of coverage with coverage effective as of January 1, 1990, under the terms which:

a. Does not provide for any waiting period with respect to treatment of preexisting conditions;

b. Provides for coverage which is substantially equivalent to coverage in effect before the date of such termination; and

c. Provides for classification of premiums on which terms are at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage never terminated.

(b) An insurer is not required to make the offer under par. (a) in the case of an individual who is a policyholder or certificateholder in another medicare supplemental policy as of January 1, 1990, if the individual is not subject to a waiting period with respect to treatment of a preexisting condition under such other policy.

(21) COMMISSION LIMITATIONS.

(a) An insurer may provide commission or other compensation to an agent or other representative for the sale of a medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than 150 percent (150%) of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

(b) The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for at least five renewal years.

(c) If an existing policy or certificate is replaced, no entity may provide compensation to its agents or other producers and no agent or producer

may receive compensation greater than the renewal compensation payable by the replacing insurer on the policy or certificate unless benefits of the new policy or certificate are clearly and substantially greater than the benefits under the replaced policy.

(d) For purposes of this section, "compensation" includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards, finder's fees, and policy fees.

(22) REQUIRED DISCLOSURE PROVISIONS.

(a) Medicare supplement policies shall include a renewal or continuation provision. The language or specifications of such provision must be consistent with the type of contract issued. Such provision shall be appropriately captioned and shall appear on the first page of the policy.

(b) Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured, exercises a specifically reserved right under a medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits; all riders or endorsements added to a medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for medicare supplement insurance policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

(c) A medicare supplement policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

(d) If a medicare supplement policy contains any limitations with respect to preexisting conditions, such limitations must appear on the first page.

(e) Medicare supplement policies or certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

(f) As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, every insurer, health care service plan or other entity providing medicare supplement insurance or benefits to a resident of this state shall notify its policyholders, contractholders and certificateholders of modifications it has made to medicare supplement insurance policies or contracts in the format similar to Appendix 4. The notice shall:

1. Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the medicare supplement insurance policy or contract, and

2. Inform each covered person as to when any premium adjustment is to be made due to changes in Medicare.

(g) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

(h) Such notices shall not contain or be accompanied by any solicitation.

(23) REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE.

(a) Application forms for Medicare supplement coverage shall comply with all relevant statutes and rules. The application form, or a supplementary form signed by the applicant and agent, shall include the following questions:

1. Do you have another medicare supplement insurance policy or certificate in force (including health care service contract or health maintenance organization contract)?

2. Did you have another medicare supplement policy or certificate in force during the last twelve (12) months?

a. If so, with which company?

b. If that policy lapsed, when did it lapse?

3. Are you covered by Medicaid?

4. Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

(b) Agents shall list, in a supplementary form signed by the agent and submitted to the insurer with each application for Medicare supplement coverage, any other health insurance policies they have sold to the applicant as follows.

1. Any policy sold which is still in force.

2. Any policy sold in the past five (5) years which is no longer in force.

(c) Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent, shall furnish the applicant, prior to issuance or delivery of the medicare supplement policy or

certificate, a notice regarding replacement of accident and sickness coverage. One copy of such notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the insurer. A direct response insurer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of accident and sickness coverage.

(d) The notice required by par. (c) for an insurer, other than a direct response insurer, shall be provided in substantially the form as shown in Appendix 5. Direct response insurer shall use a notice in substantially the form as shown in Appendix 6.

(24) STANDARDS FOR MARKETING.

(a) Every insurer marketing medicare supplement insurance coverage in this state, directly or through its producers, shall:

1. Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

2. Establish marketing procedures to assure excessive insurance is not sold or issued.

3. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance.

(b) Every insurer marketing medicare supplement insurance shall establish auditable procedures for verifying compliance with par. (a).

(c) In addition, the following acts and practices are prohibited:

1. "Twisting." Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for

the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

2. "High pressure tactics." Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

3. "Cold lead advertising." Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose is solicitation of the purchase of insurance and that contact will be made by an agent or insurer.

(d) Establish marketing procedures which set forth a mechanism or formula for determining whether a replacement policy or certificate contains benefits clearly and substantially greater than the benefits under the replaced policy for purposes of triggering first year commissions as authorized in sub. (21).

(e) In regards to any transaction involving a medicare supplement policy, no person subject to regulation under chs. 600 to 655, Stats., may knowingly prevent or dissuade or attempt to prevent or dissuade, any person from:

1. Filing a complaint with the office of the commissioner of insurance; or

2. Cooperating with the office of the commissioner of insurance in any investigation; or

3. Attending or giving testimony at any proceeding authorized by law.

(25) APPROPRIATENESS OF RECOMMENDED PURCHASE AND EXCESSIVE INSURANCE.

(a) In recommending the purchase or replacement of any medicare supplement policy or certificate, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(b) Any sale of medicare supplement coverage which will provide an individual more than one medicare supplement policy or certificate is prohibited.

(26) REPORTING OF MULTIPLE POLICIES.

(a) On or before March 1, every insurer providing medicare supplement insurance coverage in this state shall report the following information for every individual resident of this state for which the insurer has in force more than one medicare supplement insurance policy or certificate:

1. Policy and certificate number, and

2. Date of issuance.

(b) The items in par. (a) must be grouped by individual policyholder.

(27) WAITING PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES.

(a) If a medicare supplement policy or certificate replaces another medicare supplement policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting condition waiting periods in the new medicare supplement policy for similar benefits to the extent time was satisfied under the original policy.

(28) GROUP POLICY CONTINUATION AND CONVERSION REQUIREMENTS.

(a) If a group medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in sub. (c), the insurer shall offer certificateholders at least the following choices:

1. An individual medicare supplement policy which provides for continuation of the benefits contained in the group policy; and

2. An individual medicare supplement policy which provides only such benefits as are required to meet the minimum standards in sub. (5) (c).

(b) If membership in a group is terminated, the insurer shall:

1. Offer the certificateholder such conversion opportunities as are described in para. (a); or

2. At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy for the time specified in s. 632.897, Stats.

(c) If a group medicare supplement policy is replaced by another group medicare supplement policy, the succeeding insurer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any limitation for preexisting conditions that would have been covered under the group policy being replaced.

NOTE: This rule requires the use of a rate change transmittal form which may be obtained from the Office of the Commissioner of Insurance, P. O. Box 7873, Madison, WI 53707-7873.

SECTION 31. Ins 3.39 Appendix is repealed and recreated to read:

APPENDIX 1

(COMPANY NAME)

OUTLINE OF MEDICARE SUPPLEMENT INSURANCE

or

OUTLINE OF MEDICARE REPLACEMENT INSURANCE

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

(1) Read Your Policy Carefully--This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. READ YOUR POLICY CAREFULLY!

(2) (a) The outline of coverage for a medicare supplement insurance policy shall contain the following language:

Medicare Supplement Insurance Policy: This policy supplements Medicare. It covers some hospital, skilled nursing facility, medical, surgical, and other outpatient services which are partially covered by Medicare. It will not cover all your health care expenses. The policy does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing, and taking medicine.

(b) The outline of coverage for a medicare replacement insurance policy shall contain the following language:

Medicare Replacement Insurance Policy: This policy provides basic Medicare hospital and physician benefits. It also includes benefits beyond those provided by Medicare. This policy is a replacement for Medicare and is subject to certain limitations in choice of providers and area of service. The policy does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing, and taking medicine.

(3) (a) In 24-point type: For medicare supplement policies marketed by intermediaries:

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

(b) In 24-point type: For medicare supplement policies marketed by direct response:

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

(c) For medicare replacement policies:

(Insert company's name) has contracted with Medicare to provide Medicare benefits. Except for emergency care anywhere or urgently needed care when you are temporarily out of the service area, all services, including all Medicare services, must be provided or authorized by (insert company's name).

(4) (a) For medicare supplement policies, provide a brief summary of the major benefits and gaps in Medicare Parts A & B with a parallel description of supplemental benefits, including dollar amounts, as outlined in these charts.

(b) For medicare replacement policies, provide a brief summary of both the basic Medicare benefits in the policy and additional benefits using the basic format as outlined in these charts and modified to accurately reflect the benefits.

(c) If the coverage is provided by a health maintenance organization as defined in s. 609.01 (2), Stats., provide a brief summary of the coverage for emergency care anywhere and urgent care received outside the service area if this care is treated differently than other covered benefits.

MEDICARE SUPPLEMENT POLICIES--PART A BENEFITS
(Insurers should include only the wording which applies to their policy's "This Policy Pays" column and complete the "You Pay" column)

MEDICARE PART A BENEFITS	PER BENEFIT PERIOD	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
Hospitalization Semiprivate room and board, general nursing and miscellaneous hospital services and supplies. Includes meals, special care units, drugs, lab tests, diagnostic x-rays, medical supplies, operating and recovery room, anesthesia and rehabilitation services.	First 60 days	All but $(current deductible)	$0 or ($) or /_/ OPTIONAL PART A DEDUCTIBLE RIDER*	
	61st to 90th days	All but $(current amount per day	$(current amount per day)	
	91st to 150th days	All but $(current amount per day	$(current amount per day)	
	Beyond 150 days	Nothing	All	
Skilled nursing care in a facility approved by Medicare. Confinement must meet Medicare standards. You must have been in a hospital for at least three days and enter the facility within 30 days after discharge.	First 20 days	100% of costs	$0	
	Additional 80 days	All but $(current amount per day)	$(current amount per day)	
	Beyond 100 days	$0	All up to 265 additional days per benefit period	
Inpatient psychiatric care in a participating psychiatric hospital		190 days per lifetime	175 days per lifetime	
Blood		All but 1st 3 pints	First 3 pints	

*These are optional riders. You purchased this benefit if the box is checked and you paid the premium.

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MEDICARE PART A BENEFITS	PER BENEFIT PERIOD	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
Home health care		100% of charges for visits considered medically necessary by Medicare	40 visits or 365 visits or /7 OPTIONAL ADDITIONAL HOME HEALTH CARE RIDER*	

MEDICARE SUPPLEMENT POLICIES--PART B BENEFITS

MEDICARE PART B BENEFITS	PER CALENDAR YEAR	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
Medical expenses Eligible expenses for physician's services, in-patient and out-patient medical services and supplies at a hospital, physical and speech therapy, ambulance, and outpatient psychiatric care	Initial ($) deductible	$0	Nothing or ($) or /_/ OPTIONAL PART B DEDUCTIBLE RIDER*	
	After initial deductible	80% of Medicare approved charge	20% of Medicare approved charge or The difference between Medicare approved charge and usual and customary charge or /_/ OPTIONAL MEDICARE PART B USUAL AND CUSTOMARY RIDER*	
Outpatient prescription drugs		$0	$0 or 75% of outpatient prescription drugs with a deductible of not more than $100 or /_/ OPTIONAL OUTPATIENT PRESCRIPTION DRUG USUAL AND CUSTOMARY CHARGES RIDER*	
Part B policy limits per calendar year			No limit	

*These are optional riders. You purchased this benefit if the box is checked and you paid the premium.

(5) All limitations and exclusions, including each of the following, must be listed under the caption LIMITATIONS AND EXCLUSIONS if benefits are not provided:

(a) Nursing home care costs (beyond what is covered by Medicare and the Wisconsin 30-day skilled nursing mandated by s. 632.895 (3), Stats.),

(b) Home health care above number of visits covered by Medicare and the 40-visit mandated by s. 632.895 (2), Stats.,

(c) Physician charges above Medicare's approved charge,

(d) Outpatient prescription drugs,

(e) Most care received outside of U.S.A.,

(f) Dental care, dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for and the cost of eyeglasses or hearing aids, unless eligible under Medicare.

(g) Coverage for emergency care anywhere or for care received outside the service area if this care is treated differently than other covered benefits, and

(h) Waiting period for pre-existing conditions.

(i) There are limitations on the choice of providers or the geographical area served (if applicable).

(j) Usual, customary, and reasonable limitations.

(6) Conspicuous statements as follows:

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

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

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

(8) Information on how to file a claim for services received from non-participating providers because of an emergency in the area or out of the service area shall be prominently disclosed.

(9) If there are restrictions on the choice of providers, a list of providers available to enrollees shall be included with the outline of coverage.

(10) A description of the review and appeal procedure for denied claims.

(11) The premium for the policy and riders, if any, in the following format:

MEDICARE SUPPLEMENT PREMIUM INFORMATION

Annual Premium

$( ) BASIC MEDICARE SUPPLEMENT POLICY

(Note: If any of the optional coverages are included in the policy without using a rider, the title and description below must be listed here and not as an optional coverage.)

OPTIONAL BENEFITS FOR MEDICARE SUPPLEMENT POLICY

(Note: Only optional coverages provided by rider shall be listed here.)

$( ) 1. Part A deductible

100% of Part A deductible

$( ) 2. Additional home health care

An aggregate of 365 visits per year including those covered by Medicare

$( ) 3. Part B deductible

100% of Part B deductible

$( ) 4. Part B usual and customary charges

Difference between Medicare approved charges and the usual and customary charges as determined by the insurer

$( ) 5. Usual and customary outpatient prescription drug charges

75% of the usual and customary after a deductible of no more than $100.

$( ) 6. Foreign travel rider

After a deductible not greater than $250, covers at least 80% of expenses associated with medical care received outside the USA for a minimum of 30 days.

$( ) TOTAL FOR BASIC POLICY AND SELECTED OPTIONAL BENEFITS

(Note: The soliciting agent should enter the appropriate premium amounts and the total at the time this outline is given to the applicant.)

(12) If premiums for each rating classification are not listed in the outline of coverage under sub (11), then the insurer shall give a separate schedule of premiums for each rating classification with the outline of coverage.

(13) A summary of or reference to the coverage required by applicable statutes.

(14) The term "certificate" should be substituted for the word "policy" throughout the outline of coverage where appropriate.

SECTION 32. Ins 3.39 Appendices 2, 3, 4, 5, and 6 are created to read:

APPENDIX 2

ADVERTISING
CERTIFICATE OF COMPLIANCE

I, _____ (name), an officer of _____ (company name) hereby certify that I have authority to bind and obligate the company by filing this (these) advertisement(s). I further certify that, to the best of my information, knowledge, and belief:

(NOTE: If the advertisement is filed by an agent, then use the following paragraph as the first paragraph:

I, _____, insurance agent, hereby certify that to the best of my information, knowledge, and belief:)

1. I have reviewed Wisconsin Statutes and administrative rules and the accompanying advertisement(s) as identified by the attached listing comply(ies) with all applicable provisions of the Wisconsin Statutes and with all applicable administrative rules of the Commissioner of Insurance;

2. The advertisement(s) does (do) not contain any inconsistent, ambiguous, or misleading language;

3. The attached advertisement(s) is (are) in final printed format or typed facsimile and is (are) as will be used in Wisconsin.

_____
(signature)

_____
(title)

_____
(date)

Individual responsible for this filing:

Name: _____ Title: _____

Address: _____

Phone Number: _____ Date: _____

APPENDIX 3

Bureau of Market Regulation
OFFICE OF THE COMMISSIONER OF INSURANCE
P. O. Box 7873
Madison, Wisconsin 53707-7873

Ref. s. Ins 3.39 (15), Wis. Adm. Cod

ADVERTISING FORM TRANSMITTAL

PLEASE REFER TO INSTRUCTIONS WHEN COMPLETING FORM. The instructions may be obtained from the Insurance Commissioner's office at the above address.

1. Company OCI Number | | | - | | | | | | | | - | |

FOR OCI USE ONLY
2. Submission Number | | | | | | | | |

1a. Agent OCI License Number | | | | | | | |

3. Company/Agent Name and Mailing Address

4. Individual Responsible for This Filing

5. Telephone Number

6. Advertisement Title	7. Form Number [s. Ins 3.27 (26)]	8. Coverage Class (Numeric)	9. Code (Alpha)	10. Type of Advertisin (Alpha)

(If more space is required, use additional forms.)

11. ☐ Certificate of Compliance - Ref. Ins 3.39 (15)

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APPENDIX 4

(COMPANY NAME)

NOTICE OF CHANGES IN MEDICARE AND YOUR MEDICARE SUPPLEMENT COVERAGE - 1990

THE FOLLOWING CHART BRIEFLY DESCRIBES THE MODIFICATIONS IN MEDICARE AND IN YOUR MEDICARE SUPPLEMENT COVERAGE. PLEASE READ THIS CAREFULLY!

[A BRIEF DESCRIPTION OF THE REVISIONS TO MEDICARE PARTS A & B WITH A PARALLEL DESCRIPTION OF SUPPLEMENTAL BENEFITS WITH SUBSEQUENT CHANGES, INCLUDING DOLLAR AMOUNTS, PROVIDED BY THE MEDICARE SUPPLEMENT COVERAGE IN SUBSTANTIALLY THE FOLLOWING FORMAT.]

SERVICES	MEDICARE BENEFITS		YOUR MEDICARE SUPPLEMENT COVERAGE	
	In 1989 Medicare Pays Per Benefit Period	Effective January 1, 1990, Medicare Will Pay	In 1989 Your Coverage Pays	Effective January 1, 1990, Your Coverage Will Pay Per Calendar Year
MEDICARE PART A SERVICES AND SUPPLIES				
Inpatient Hospital Services	Unlimited number of hospital days after $560 deductible	All but $592 for first 60 days/benefit period		
Semi-Private Room & Board		All but $148 a day for 61st-90th days/ benefit period		

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Misc. Hospital Services 7Supplies, such as Drugs, X-Rays, Lab Tests & Operating Room		All but $296 a day for 91st-150th days (if individual chooses to use 60 nonrenewable lifetime reserve days)
BLOOD	Pays all costs except payment of deductible (equal to costs for first 3 pints) each calendar year. Part A blood deductible reduced to the extent paid under Part B	pays all costs except nonreplacement fees (blood deductible) for first 3 pints of each benefit period
SKILLED NURSING FACILITY CARE	There is no prior confinement requirement for this benefit	100% of costs for 1st 20 days (after a 3-day period hospital confinement)/ benefit period
	First 8 days - all but $25.50 a day	All but $74.00 a day for 21st-100th days/benefit period
	9th through 150th day - 100% of costs period	Beyond 100 days - nothing/benefit
	Beyond 150 days - nothing	
MEDICARE PART B SERVICES AND SUPPLIES	80% of allowable charges (after $75 deductible calendar year)	80% of allowable charges (after $75 deductible/

PRESCRIPTION DRUGS	Inpatient prescription drugs. 80% of allowable charges for immuno-suppressive drugs during the first year following a covered transplant (after $75 deductible/ calendar year)	Inpatient prescription drugs. 80% of allowable charges for immuno-suppressive drugs during the first year following a covered transplant (after $75 deductible/ calendar year)
BLOOD	80% of all costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period (after $75 deductible/ calendar year)	80% of costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period (after $75 deductible/ calendar year)

[Any other policy benefits not mentioned in this chart should be added to the chart in the order prescribed by the outline of coverage benefits, they should be shown.]

[Describe any coverage provisions changing due to Medicare modifications.]

[Include information about when premium adjustments that may be necessary due to changes in Medicare benefits will be effective.]

THIS CHART SUMMARIZING THE CHANGES IN YOUR MEDICARE BENEFITS AND IN YOUR MEDICARE SUPPLEMENT PROVIDED BY (COMPANY) ONLY BRIEFLY DESCRIBES SUCH BENEFITS. FOR INFORMATION ON YOUR MEDICARE BENEFITS CONTACT YOUR SOCIAL SECURITY OFFICE OR THE HEALTH CARE FINANCING ADMINISTRATION. FOR INFORMATION ON YOUR MEDICARE SUPPLEMENT POLICY CONTACT:

[COMPANY OR FOR AN INDIVIDUAL POLICY - NAME OF AGENT] [ADDRESS/PHONE NUMBER]

APPENDIX 5

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT INSURANCE

(Insurance company's name and address)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing medicare supplement insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy provides thirty (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this medicare supplement coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT [BROKER OR OTHER REPRESENTATIVE]:
(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate, may not contain new preexisting condition waiting periods. The insurer will waive any time periods applicable to preexisting condition waiting periods in the new policy (or coverage) for similar benefits to the extent such time was satisfied under the original policy.

3. If you are replacing existing medicare supplement insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all requested material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all requested information has been properly recorded.

_____

Signature of Agent, Broker or Other Representative

_____

[Typed Name and Address of Agent or Broker]

The above "Notice to Applicant" was delivered to me on:

_____

(Date)

_____

(Applicant's Signature)

APPENDIX 6

The replacement notice for a direct response insurer shall be as follows:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT INSURANCE

(Insurance company's name and address)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing medicare supplement insurance and replace it with the policy delivered herewith issued by [Company Name] Insurance Company. Your new policy provides thirty (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this medicare supplement coverage is a wise decision.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate, may not contain new preexisting condition waiting periods. The insurer will waive any time periods applicable to preexisting condition waiting periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing medicare supplement insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. [To be included only if the application is attached to the policy.]

   If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the

application and write to [Company Name and Address] within thirty (30) days if any requested information is not correct and complete, or if any requested past medical history has been left out of the application.

_____

(Company Name Agent)

SECTION 33. Ins 25.03, Ins 25.04, Ins 25.05 and Ins 25 Appendices 1, 2, 3, 4, 5 and 6 are repealed.

EFFECTIVE DATE: Ins 3.39 (21) to (24) and Ins 3.39 (28) shall be applicable to any policy solicited after August 1, 1990, and any policy with an effective date on or after August 1, 1990. All other changes are effective on the day after publication.

May 7, 1990
Date

Robert D. Haase
Commissioner of Insurance

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