Chapter Ins 3

CASUALTY INSURANCE

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

Ins 3.02 Automobile fleets, vehicles not included in. Individually owned motor vehicles cannot be included or covered by fleet rates. The determining factor for inclusion under fleet coverage must be ownership and not management or use.

Ins 3.04 Dividends not deducted from premiums in computing loss reserves. Premiums returned to policyholders as dividends may

not be deducted from the earned premiums in computing loss reserves under s. 623.04, Stats.

History: 1-2-66; emerg. am. eff. 6-22-76; am. Register, September, 1976, No. 249, eff. 10-1-76.

Ins 3.09 Mortgage guaranty insurance. (1) PURPOSE. This rule implements and interprets, including but not limited to, s. Ins 6.75 (2) (i) and ss. 611.02, 611.24, 618.01, 618.21, 620.02 and 623.04, Stats., for the purpose of establishing minimum requirements for the transaction of mortgage guaranty insurance.

(2) SCOPE. This rule shall apply to the underwriting, investment, marketing, rating, accounting and reserving activities of insurers which write the type of insurance authorized by s. Ins 6.75 (2) (i).

(3) DEFINITIONS. (a) Mortgage guaranty insurance is that kind of insurance authorized by s. Ins 6.75 (2) (i), and includes the guarantee of the payment of rentals under leases of real estate in which the lease extends for 3 years or longer.

(b) As used in this rule, "person" means any individual, corporation, association, partnership or any other legal entity.

(4) DISCRIMINATION. No mortgage guaranty insurer may discriminate in the issuance or extension of mortgage guaranty insurance on the basis of the applicant's sex, marital status, race, color, creed or national origin.

(5) LIMITATION OF TOTAL LIABILITY ASSUMED. A mortgage guaranty insurer shall not at any time have outstanding a total liability under its aggregate insurance policies, computed on the basis of its election to limit coverage and net of reinsurance assumed and of reinsurance ceded to an insurer authorized to transact such reinsurance in this state, exceeding 25 times the sum of its contingency reserve established under sub. (14) and its surplus as regards policyholders.

(6) LIMITATION ON INVESTMENT. A mortgage guaranty insurer shall not invest in notes or other evidences of indebtedness secured by mortgage or other lien upon real property. This section shall not apply to obligations secured by real property, or contracts for the sale of real property, which obligations or contracts of sale are acquired in the course of the good faith settlement of claims under policies of insurance issued by the mortgage guaranty insurer, or in the good faith disposition of real property so acquired.

(7) LIMITATION ON ASSUMPTION OF RISKS. A mortgage guaranty insurer shall not insure loans secured by properties in a single or contiguous housing or commercial tract in excess of 10% of the insurer's admitted assets. A mortgage guaranty insurer shall not insure a loan secured by a single risk in excess of 10% of the insurer's admitted assets. In determining the amount of such risk or risks, the insurer's liability shall be computed on the basis of its election to limit coverage and net of reinsurance ceded to an insurer authorized to transact such reinsurance in this state. "Contiguous" for the purpose of this subsection means not separated by more than one-half mile.

(8) REINSURANCE. A mortgage guaranty insurer may, by contract, reinsure any insurance it transacts in any assuming insurer authorized to transact mortgage guaranty insurance in this state, except it shall not

enter into reinsurance arrangements designed to circumvent the compensation control provisions of sub. (15) or the contingency, reserve requirement of sub. (14). It is the intent of this rule that the unearned premium reserve required by sub. (13) and the contingency reserve required by sub. (14) shall be established and maintained in appropriate proportions in relation to risk retained by the original insurer and by the assuming reinsurer so that the total reserves established shall not be less than the reserve required by subs. (13) and (14).

(9) ADVERTISING. No mortgage guaranty insurer or any agent or representative of a mortgage guaranty insurer shall prepare or distribute or assist in preparing or distributing any brochure, pamphlet, report or any form of advertising to the effect that the real estate investments of any financial institution are "insured investments", unless the brochure, pamphlet, report or advertising clearly states that the loans are insured by insurers possessing a certificate of authority to transact mortgage guaranty insurance in this state or are insured by an agency of the federal government, as the case may be.

(10) POLICY FORMS. All policy forms and endorsements shall be filed with and be subject to approval of the commissioner. With respect to owner-occupied, single-family dwellings, the mortgage guaranty insurance policy shall provide that the borrower shall not be liable to the insurance company for any deficiency arising from a foreclosure sale.

(11) PREMIUM. (a) The total consideration charged for mortgage guaranty insurance policies, including policy and other fees or similar charges, shall be considered premium and must be stated in the policy and shall be subject to the reserve requirements of subs. (13) and (14).

(b) The rate making formula for mortgage guaranty insurance shall contain a factor or loading sufficient to produce the amount required for the contingency reserve prescribed by sub. (14).

(12) REPORTING. (a) The financial condition and operations of a mortgage guaranty insurer shall be reported annually on the fire and casualty annual statement form specified by s. Ins 7.01 (5) (a), Wis. Adm. Code.

(b) The total contingency reserve required by sub. (14) shall be reported on line 1, page 3 or on line 22, page 3 of the annual statement. If the contingency reserve is reported on line 1, page 3, appropriate entries must be made on Exhibit 3-A, page 9 of the annual statement. The change in contingency reserve for the year shall be reported on line 5, page 4 of the annual statement as a deduction from underwriting income. The development of the contingency reserve shall be shown in Schedule K of the annual statement as follows:

1. Net premiums earned on policies during the 120 months prior to the annual statement date shall be shown on line 3 (a) of Schedule K;

2. Incurred losses in excess of 35% of earned premiums of any calendar year included in line 3 (a) shall be reported in line 3 (c) of Schedule K; and

3. Appropriate entries shall be made in lines 3 (b), 3 (d), 3 (e), 3 (f), (4) and (5) of Schedule K.

(c) A mortgage guaranty insurer shall compute and maintain adequate case basis and other loss reserves to be reported in Underwriting and Investment Exhibit Part 3-A—Unpaid Losses and Loss Adjustment Expenses, page 9 of the annual statement form. The method used to determine the loss reserve shall accurately reflect loss frequency and loss severity and shall include components for claims reported and unpaid, and for claims incurred but not reported, including estimated losses on:

1. Insured loans which have resulted in the conveyance of property which remains unsold;

2. Insured loans in the process of foreclosure;

3. Insured loans in default for 4 months or for any lesser period which is defined as default for such purposes in the policy provisions; and

4. Insured leases in default for 4 months or for any lesser period which is defined as default for such purposes in the policy provisions.

(d) Expenses shall be recorded and reported in accordance with ss. Ins 6.30 and 6.31, Wis. Adm. Code.

(e) Amounts released from the contingency reserve pursuant to sub. (14) shall be treated on a first-in-first-out basis.

(13) UNEARNED PREMIUM RESERVE. (a) A mortgage guaranty insurer shall compute and maintain an unearned premium reserve on an annual or on a monthly pro rata basis on all unexpired coverage, except that in the case of premiums paid in advance for any coverage issued with a term shown in the schedule below the annual unearned premium factor specified shall apply:

Unearned Premium Factor to be Applied to Premiums in Force on Valuation Date

Contract Year Current at Valuation Date	4 Year Coverage Period	5 Year Coverage Period	6 Year Coverage Period	7 Year Coverage Period	8 Year Coverage Period	9 Year Coverage Period
1	95.7%	96.5%	97.0%	97.3%	97.5%	97.7%
2	76.4%	81.0%	83.7%	85.4%	86.6%	87.3%
3	45.2%	56.0%	62.2%	66.2%	68.8%	70.4%
4	14.5%	31.3%	41.1%	47.4%	51.3%	53.8%
5		9.8%	22.7%	31.0%	36.2%	39.4%
6			7.1%	17.1%	23.3%	27.2%
7				5.4%	12.5%	16.9%
8					3.8%	8.6%
9						2.5%
10						
11						
12						
13						
14						
15						

a. Summarizing the benefits provided by Medicare Parts A and B;

b. Summarizing the Medicare supplement benefits provided by the policy; and

c. Indicating what Medicare eligible expenses remain uncovered by Medicare and the policy;

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

3. Contains conspicuous statements:

a. That Medicare will not pay for charges it deems "unreasonable and unnecessary";

b. Unless the policy explicitly provides otherwise, that the policy will not pay for charges deemed "unreasonable and unnecessary" by Medicare;

c. Unless the policy explicitly provides otherwise, that the policy will not cover expenses outside of Medicare such as routine doctor examinations or eye glasses;

d. That the chart summarizing Medicare benefits only briefly describes the program; and

e. That the federal social security administration or its Medicare publications should be consulted for further details and limitations regarding Medicare;

4. Contains in a close conjunction on its first page the Designation, printed in capitals in a clear, contrasting ink in 24-point type of a style in general use, and the Caption, printed in a clear, contrasting ink in 18-point type of a style in general use, prescribed in subsection (5);

5. Complies with (7) (b) 1.; and

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

7. Is submitted to the commissioner for approval along with the policy form.

(5) AUTHORIZED MEDICARE SUPPLEMENT POLICY DESIGNATIONS, CAPTIONS AND MINIMUM COVERAGES. For a policy to meet the requirements of subsection (4), it must contain the authorized Designation, Caption and Minimum Coverage prescribed for one of the following categories of Medicare Supplement insurance.

(a) A MEDICARE SUPPLEMENT 1 policy must include:

1. The following Designation: MEDICARE SUPPLEMENT 1

2. The following Caption: The State Insurance Commissioner's Office has established three categories of Medicare Supplement insurance and minimum benefit standards for each. These categories range from the most comprehensive (Medicare Supplement 1) to the least comprehensive (Medicare Supplement 3). For an explanation of the differences between this "1" policy and policies in the other categories, consult the commissioner's pamphlet "Health Insurance Advice for Senior Citi-

zens" which you received with the application for this policy. Do not buy this policy if you did not get this pamphlet and were not given a chance to review the Outline of Coverage provided you.

3. The following Minimum Coverage: This level of coverage shall at a minimum cover all Medicare eligible expenses listed below to at least a stated maximum of $22,500 per benefit period (inclusive of Medicare Parts A and B) or $15,000 per benefit period for Medicare Part A and $7,500 per calendar year for Medicare Part B. Benefits shall be provided for the enumerated expenses up to the stated maximum beyond the day limitations established by Medicare unless a minimum period is specified below.

a. The following Medicare Part A eligible expenses:

1) Hospitalization, including inpatient psychiatric care

2) Extended Care Services in a Skilled Nursing Facility

3) Home Health Care (post-hospital)

4) Blood

b. The following Medicare Part B eligible expenses:

1) Physician's services (except for routine physical examinations)

2) Home Health Care

3) Outpatient Hospital Services

i. Services in an emergency room or outpatient clinic

ii. Laboratory tests billed by a hospital

iii. X-rays and other radiology services billed by a hospital

iv. Medical supplies such as splints and casts

v. Drugs and biologicals which cannot be self-administered

4) Outpatient Physical Therapy and Speech Pathology Services

5) Other Health Services and Supplies

i. Diagnostic x-rays and independent laboratory tests

ii. Ambulance

iii. Medical supplies

iv. Prosthetic devices

v. Durable medical equipment

vi. Portable diagnostic x-ray services

6) Blood

c. Coverage shall be provided for at least 75% of prescription drug expenses and 50% of outpatient psychiatric treatment up to a separate lifetime maximum of at least $1,000.

(b) A MEDICARE SUPPLEMENT 2 policy must include:

1. The following Designation: MEDICARE SUPPLEMENT 2

2. The following Caption: The State Insurance Commissioner's Office has established three categories of Medicare Supplement insurance and minimum benefit standards for each. These categories range from the most comprehensive (Medicare Supplement 1) to the least comprehensive (Medicare Supplement 3). For an explanation of the differences between this "2" policy and policies in the other categories, consult the Commissioner's pamphlet "Health Insurance Advice for Senior Citizens" which you received with the application for this policy. Do not buy this policy if you did not get this pamphlet and were not given a chance to review the Outline of Coverage provided you.

3. The following Minimum Coverage: This level of coverage shall at a minimum cover all Medicare eligible expenses listed below to at least a stated maximum of $15,000 per benefit period (inclusive of Medicare Parts A and B) or $10,000 per benefit period for Medicare Part A and $5,000 per calendar year for Medicare Part B. Benefits shall be provided for the enumerated expenses up to the stated maximum beyond the day limitations established by Medicare.

a. The following Medicare Part A eligible expenses:

1) Hospitalization, including inpatient psychiatric care

2) Extended Care Services in a Skilled Nursing Facility

3) Home Health Care (post-hospital)

b. The following Medicare Part B eligible expenses:

1) Physician's services (except for routine physical examinations)

2) Home Health Care

3) Outpatient Hospital Services

i. Services in an emergency room or outpatient clinic

ii. Laboratory tests billed by a hospital

iii. X-rays and other radiology services billed by a hospital

iv. Medical supplies such as splints and casts

v. Drugs and biologicals which cannot be self-administered

4) Outpatient Physical Therapy and Speech Pathology Services

5) Other Health Services and Supplies

i. Diagnostic x-rays and independent laboratory tests

ii. Ambulance

iii. Medical supplies

(c) A MEDICARE SUPPLEMENT 3 policy must include:

1. The following Designation: MEDICARE SUPPLEMENT 3

2. The following Caption: The State Insurance Commissioner's Office has established three categories of Medicare Supplement insurance and minimum benefit standards for each. These categories range from the

most comprehensive (Medicare Supplement 1) to the least comprehensive (Medicare Supplement 3). For an explanation of the differences between this "3" policy and policies in the other categories, consult the Commissioner's pamphlet "Health Insurance Advice for Senior Citizens" which you received with the application for this policy. Do not buy this policy if you did not get this pamphlet and were not given a chance to review the Outline of Coverage provided you.

3. The following Minimum Coverage: This level of coverage shall at a minimum cover all Medicare eligible expenses listed below to at least a stated maximum of $6,500 per benefit period (inclusive of Medicare Parts A and B) or $5,000 per benefit period for Medicare Part A and $1,500 per calendar year for Medicare Part B. Benefits shall be provided for the enumerated expenses up to the stated maximum beyond the day limitations established by Medicare unless a minimum period is specified below.

a. The following Medicare Part A eligible expenses:

1) Hospitalization to the 90th day of confinement including inpatient psychiatric care

2) Co-payment for each of 30 lifetime reserve days of hospital confinement

3) Extended Care Services in a Skilled Nursing Facility to the 100th day of confinement

b. The following Medicare Part B eligible expenses:

1) Physician's services (except for routine physical examinations)

2) Outpatient Hospital Services

i. Services in an emergency room or outpatient clinic (not including physical therapy or speech pathology)

ii. Laboratory tests billed by a hospital

iii. X-rays and other radiology services billed by a hospital

iv. Medical supplies such as splints and casts

3. Ambulance

(6) PERMISSIBLE MEDICARE SUPPLEMENT POLICY EXCLUSIONS AND LIMITATIONS. (a) The coverages set out in subsection (5) may:

1. Exclude expenses for which the insured is compensated by Medicare.

2. Exclude coverage for the initial deductibles for Medicare Parts A and B.

3. Include any exclusion or condition contained in Medicare, except that inhospital treatment of mental illness shall be covered the same as any other illness.

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

5. Except for a Medicare Supplement 1 policy for which a specific requirement is set out in subsection (5) (a) 3. c., limit coverage of outpatient psychiatric treatment to 50% of the reasonable and necessary charges and to a lifetime benefit of $500.

6. Contain a pre-existing condition waiting period provision as provided in subsection (4) (a) 2.

(b) Where the insured chooses not to enroll in Medicare Part B, the insurer may exclude from coverage the expenses which Medicare Part B would cover. Medicare Part B expenses incurred beyond what Medicare Part B would cover may not be excluded.

(7) NURSING HOME, HOSPITAL CONFINEMENT INDEMNITY AND SPECIFIED DISEASE COVERAGES. (a) Captions for the policies listed in this subsection shall be:

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

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

3. Printed in 18-point bold capital letters.

(b) Nursing Home Coverage.

1. The Outline of Coverage for a policy subject to subsection (5) which provides Skilled Nursing Facility Coverage shall contain clear and conspicuous statements that:

a. The nursing home coverage will not cover all nursing home expenses,

b. Only eligible nursing home expenses as defined in the policy will be covered.

c. Medicare pays no benefits for custodial care or rest home care, and

d. The policy, unless it provides otherwise, pays no benefits for custodial or rest home care.

2. A policy form which has not been approved by the commissioner under subsection (5) and which provides coverage for confinement or care in a nursing home shall provide such coverage for confinement in any nursing facility and may not exclude coverage because a nursing facility is not Medicare-certified. Such a policy sold to Medicare eligible persons shall bear the following Caption: THE NURSING HOME BENEFIT OF THIS POLICY DOES NOT RELATE IN ANY WAY TO MEDICARE. IT WILL NOT COVER CUSTODIAL CARE OR REST HOME CARE. FOR MORE INFORMATION, CONSULT THE COMMISSIONER'S PAMPHLET "HEALTH INSURANCE ADVICE FOR SENIOR CITIZENS" WHICH YOU RECEIVED WITH THE APPLICATION FOR THIS POLICY.

3. A policy which covers nursing home custodial care or rest home care may be described in the Caption as covering such care, if such Caption is accurately and reasonably worded to indicate, for example, that the policy provides limited custodial care or rest home care.

(c) Hospital Confinement Indemnity Coverage. A policy form providing hospital confinement indemnity coverage sold to a Medicare eligible person shall bear the following Caption: THE HOSPITAL CONFINEMENT INDEMNITY BENEFIT OF THIS POLICY IS NOT DESIGNED TO FILL THE GAPS IN MEDICARE. IT WILL PAY YOU ONLY A STATED DOLLAR AMOUNT FOR A DESIGNATED NUMBER OF DAYS WHEN YOU ARE HOSPITAL CONFINED. FOR MORE INFORMATION, CONSULT THE COMMISSIONER'S PAMPHLET "HEALTH INSURANCE ADVICE FOR SENIOR CITIZENS" WHICH YOU RECEIVED WITH THE APPLICATION FOR THIS POLICY.

(d) Specified Disease Coverage. A policy form providing benefits only for one or more specified diseases sold to a Medicare eligible person shall bear:

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

2. The following Caption: THIS POLICY IS DESIGNED TO COVER ONLY ONE OR MORE SPECIFIED OR RARE ILLNESSES. IT SHOULD NOT BE PURCHASED AS A SUBSTITUTE FOR HEALTH CARE EXPENSE COVERAGE WHICH WOULD GENERALLY COVER ANY ILLNESS OR INJURY. FOR MORE INFORMATION, CONSULT THE COMMISSIONER'S PAMPHLET "HEALTH INSURANCE ADVICE FOR SENIOR CITIZENS" WHICH YOU RECEIVED WITH THE APPLICATION FOR THIS POLICY.

(8) CONVERSION OR CONTINUATION OF COVERAGE. (a) An Outline of Coverage as described in par. (e) and a copy of the current edition of the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" shall be furnished by an insurer upon request to each insured who will become eligible for Medicare and is offered a conversion policy under the terms of a group insurance policy.

(b) An insurer:

1. Which provides group insurance coverage shall furnish annually to each group policyholder written notice of the availability of the information described in pars. (a) or (d), where applicable, and upon request shall furnish sufficient copies of the same or similar notice to the group policyholder to be distributed to group members affected; and

2. Which provides individual or family insurance coverage shall furnish an Outline of Coverage as described in par. (e) and a copy of the current edition of the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" at the time an insured who will become eligible for Medicare is furnished an application for conversion.

(c) Except as provided under par. (d), an insurer shall furnish an Outline of Coverage and a copy of the current edition of the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" within 14 calendar days after receipt of the request for such information.

(d) Upon request, a comprehensive written explanation of the insurance coverage to be provided after Medicare eligibility and a copy of the current edition of the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" shall be furnished by the insurer within 14 cal-

endar days after receipt of the request to each insured who will become eligible for Medicare whose coverage under an individual, family or group insurance policy will continue with changed benefits (e.g. "carve-out" or reduced benefits).

(e) The Outline of Coverage:

1. For a conversion policy which relates its benefits to or complements Medicare shall comply with subsection (4) (b) 1., 2., 3., and 6. of this rule and shall be submitted to the commissioner; and

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

(9) "HEALTH INSURANCE ADVICE FOR SENIOR CITIZENS" PAMPHLET. Every prospective Medicare eligible purchaser of any policy subject to this rule or coverage added to an existing Medicare Supplement policy must receive a copy of the current edition of the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" at the time the prospect is contacted by an intermediary or insurer with an invitation to apply as defined in Ins 3.27 (5) (g). This pamphlet prepared by the Office of the Commissioner of Insurance provides information on Medicare and advice to senior citizens on the purchase of Medicare supplement insurance and other health insurance. Insurers may obtain copies of this pamphlet from the commissioner at cost or may reproduce this pamphlet themselves. This pamphlet shall be periodically revised to reflect changes in Medicare and any other appropriate changes. No insurer shall be responsible for providing applicants the revised pamphlet until 30 days after the insurer has received notice that the revised pamphlet is available at the commissioner's office.

(10) APPROVAL NOT A RECOMMENDATION. While the commissioner may authorize the use of a particular Designation on a policy in accordance with this rule, that authorization is not to be construed or advertised as a recommendation of any particular policy by the commissioner or the state of Wisconsin.

(11) SEVERABILITY. If any provision of this rule or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the rule which can be given effect without the invalid provision or application, and to this end the parts of the rule are declared to be severable.

(12) EFFECTIVE DATE. This rule shall take effect January 1, 1978.

Note: Subsequent to the adoption of this rule but prior to its effective date the pamphlet required by sub. (9) shall be revised pursuant to the procedures of that subsection. The revised pamphlet shall include information on this rule and contain other appropriate changes.

Note: Insurers may use current supplies of forms which comply with subs. (7), (8) and (9) of the original rule which became effective January 1, 1978, until those supplies are exhausted, but all forms subject to newly created sub. (7) shall comply with this rule as amended by July 1, 1979.

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

Ins 3.40 Authorized clauses for coordination of benefit provisions in group and blanket disability insurance policies [ss. 631.20, 631.21 (1) (b), 631.23, 631.43, 632.77 (3)]. (1) PURPOSE. This section establishes authorized coordination of benefit clauses for group and blanket disability insurance policies pursuant to s. 631.23, Stats., because it has been found that provision of language, content or form of these specific clauses is necessary to provide certainty of meaning of them, and regulation of contract forms will be more effective and litigation will be substantially reduced is there is increased uniformity of these clauses. This section does not require the use of coordination of benefit or "other insurance" provisions but if such provisions are used, they must adhere substantially to this section. Liberalization of the prescribed language including rearrangement of the order of the clauses is permitted provided that the modified language is not less favorable to the insured person. Provisions for the reduction in benefits because of other insurance which are inconsistent with this section violate the criteria of s. 631.20, Stats., and may not be used.

(2) SCOPE. This section applies to all group and blanket disability insurance policies subject to s. 631.01 (1), Stats., providing 24-hour coverage for medical or dental care, treatment or expenses due to either injury or sickness which contain a coordination of benefits provision, an "excess," "anti-duplication," "non-profit" or "other insurance" clause or other provision, clause or exclusion by whatever name designated under which benefits would be reduced because of other insurance, other than an exclusion for expenses covered by workers compensation, employer's liability insurance or Medicare. A plan of coverage, such as major medical or excess medical, designed to be supplementary to a group or blanket policyholder's other coverage may provide that the plan shall be excess to that specific policyholder's plan of basic coverage from whatever source provided.

(3) AUTHORIZED CLAUSES. The clauses in subs. (4) to (10) shall be considered authorized clauses pursuant to s. 631.23, Stats., for use in policy forms subject to this section and collectively are a coordination of benefits provision and may be referred to as "this provision."

(4) BENEFITS SUBJECT TO THIS PROVISION. All of the benefits provided under this policy are subject to this provision.

(5) BENEFITS SUBJECT TO THIS PROVISION [Alternate Clause]. Only the major medical expense benefits provided under this policy are subject to this provision. [When the policy provides both integrated major medical expense benefits and the basic benefits, but the "other insurance" provision applies to the major medical expense benefits only, this alternate wording is authorized.]

(6) DEFINITIONS. (a) "Plan" means any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by group, blanket or franchise insurance coverage, service insurance plan contracts, group practice, individual practice and other prepayment coverage, or any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employe benefit organization plans, and any coverage under governmental programs, and any coverage required or provided by statute.

(am) The term "Plan" shall be construed separately with respect to each policy, contract or other arrangement for benefit or services and separately with respect to that portion of any policy, contract or other arrangement which reserves the right to take benefits or services of other plans into consideration in determining its benefits and that portion which does not.

(b) "This Plan" means that portion of this policy which provides the benefits that are subject to this provision. Any benefits provided under this policy that are not subject to this provision constitute another Plan.

(c) "Allowable Expense" means any necesary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the Plans covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

(d) "Claim Determination Period" means _____. [Insert here an appropriate period of time such as "Calendar year" or "Benefit Period as defined elsewhere in this policy."]

(7) EFFECT ON BENEFITS. (a) This provision shall apply in determining the benefits as to a person covered under this Plan for any Claim Determination Period if, for the Allowable Expense incurred as to such person during such period, the sum of

1. The benefits that would be payable under this Plan in the absence of this provision, and

2. The benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to this provision would exceed such allowable Expenses.

(b) As to any Claim Determination Period with respect to which this provision is applicable, the benefits that would be payable under this Plan in the absence of this provision for the Allowable Expenses incurred as to such person during such Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other Plans, except as provided in paragraph (c), shall not exceed the total of the Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made therefor.

(c) 1. If another Plan which is involved in paragraph (b) and which contains a provision coordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined, and

2. The other Plan's provision coordinating its benefits with those of this Plan includes Claim Determination Period and Facility of Payment provisions similar to those of this provision, and

3. The rules set forth in this subsection would require this Plan to determine its benefits before any other Plan then the benefits of the other Plan will be ignored for the purposes of determining the benefits under this Plan.

(d) For the purposes of paragraph (c), the rules establishing the order of benefit determination are:

1. The benefits of a Plan which covers the person on whose expenses claim is based other than as a dependent shall be determined before the benefits of a Plan which covers the person as a dependent;

2. The benefits of a Plan which covers the person on whose expenses claim is based as a dependent of a male person shall be determined before the benefits of a Plan which covers the person as a dependent of a female person; except that in case of a person for whom claim is made as a dependent child,

a. When parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a Plan which covers the child as a dependent of the parent without custody;

b. When parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a dependent of the stepparent, and the benefits of a Plan which covers that child as a dependent of the stepparent will be determined before the benefits of a Plan which covers that child as a dependent of the parent without custody;

c. Notwithstanding subdivisions 2. a. and b., if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a dependent child.

3. When subdivisions 1. and 2. do not establish an order of benefit determination, the benefits of a Plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered the person the shorter period of time.

(e) When this subsection operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during any Claim Determination Period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and the reduced amount shall be charged against any applicable benefit limit of this Plan. [This clause may be omitted if the Plan provides only one benefit.]

(8) RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION. For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provision of similar purpose of any other Plan, the insurer or service plan may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which the insurer or service plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the insurer or service plan such information as may be necessary to implement this provision.

(9) FACILITY OF PAYMENT. Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plans, the insurer or service plan shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it determines to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of the payments, the insurer or service plan shall be fully discharged from liability under this Plan.

(10) RIGHT OF RECOVERY. Whenever payments have been made by the insurer with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the insurer or service plan shall have the right to recover such payments, to the extent of any excess, from among one or more of the following, as the insurer or service plan shall determine: any persons to or for or with respect to whom such payments were made, any other insurers, service plans or any other organizations.

(11) LIMITATIONS ON AND VARIATIONS FROM DEFINITION OF PLAN. The definition of a Plan in sub. (6) (a) enumerates the types of coverage which the insurer may consider in determining whether overinsurance exists with respect to a specific claim. The authorized definition clause may be varied in accordance with the substance of the following:

(a) The definition may not include individual or family policies, or individual or family subscriber contracts, except as authorized in paragraphs (b) through (f).

(b) The definition may include all group policies or group subscriber contracts as well as such group-type contracts as are not available to the general public and can be obtained and maintained only because of the covered person's membership in or connection with a particular organization or group. Group-type contracts answering this description may be included in the definition, at the option of the insurer and its policyholder-client, whether or not individual policy forms are utilized and whether the group-type coverage is designated as "franchise" or "blanket" or in some other fashion.

(c) The definition may include both group and individual automobile "no-fault" contracts but, as to the traditional automobile "fault" contracts, only the medical benefits written on a group or group-type basis may be included.

(d) The definition may not include group or group-type hospital indemnity benefits written on a nonexpense incurred basis of $30 per day or less unless they are characterized as reimbursement type benefits but are designed or administered so as to give the insured the right to elect indemnity type benefits, in lieu of such reimbursement type benefits, at the time of claim. In any event, the amount of group and group-type hospital indemnity benefits which exceeds $30 per day may be construed as being included under the definition of a "Plan."

(e) The definition may not include school accident type coverages, written on either an individual, group, blanket or franchise basis. In this context, school accident type coverages are defined to mean coverage covering grammar school and high school students for accidents only,

including athletic injuries, either on a 24-hour basis or "to and from school," for which the parent pays the entire premium.

(f) If Medicare or similar governmental benefits are included in the definition of a Plan, such benefits may be taken into consideration without expanding the definition of Allowable Expenses beyond the hospital, medical and surgical benefits as may be provided by the government program.

(12) DETERMINATION OF LENGTH OF TIME COVERED. (a) In determining the length of time an individual has been covered under a given Plan, two successive Plans of a given group shall be deemed to be one continuous Plan so long as the claimant concerned was eligible for coverage within 24 hours after the prior Plan terminated. Thus, neither a change in the amount or scope of benefits provided by a Plan, a change in the carrier insuring the Plan, nor a change from one type of Plan to another, [e.g., single employer to multiple employer Plan, or vice versa, or single employer to a Taft-Hartley Welfare Plan] would constitute the start of a new Plan for purposes of this section.

(b) If a claimant's effective date of coverage under a given Plan is subsequent to the date the carrier first contracted to provide the Plan for the group concerned (employer, union, association, etc.), then, in the absence of specific information to the contrary, the carrier shall assume, for purposes of this section, that the claimant's length of time covered under that Plan shall be measured from the claimant's effective date of coverage. If a claimant's effective date of coverage under a given Plan is the same as the date the carrier first contracted to provide the Plan for the group concerned, then the carrier shall request the group concerned to furnish the date the claimant first became covered under the earliest of any prior Plans the group may have had. If such date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time coverage under that Plan has been in force.

(13) COORDINATION OF BENEFITS WITH OTHER PLAN WHOSE COVERAGE IS EXCESS TO ALL OTHER COVERAGE. It is recognized that there may be existing group plans containing provisions under which the coverage is declared to be "excess" to all other coverages, or other overinsurance provisions not consistent with the provisions of this section. Such plans may have been written by self-insured or nonregulated entities not presently subject to insurance regulation, or by insurers or service corporations under policies or contracts issued prior to the effective date of this section which have not yet been brought into conformance with this section. Carriers are urged to use the following claims administration procedures when one plan is "excess" to all other coverages and their policy or contract contains the coordination of benefits provisions of this section. A plan containing a coordination of benefits provision should pay first if it would be primary according to the oder of benefit determination of subsection (7). In those cases where a group coordination of benefits plan would normally be considered secondary, the insurer should make every effort to coordinate in a secondary position with benefits available through any such "excess" plan. The insurer should try to secure the necessary information from the "excess" plan. But if such excess plan is unwilling to provide the carrier with the necessary information, the carrier should assume the primary position in order to avoid undue claim delays and hardship to the insured.

(14) COORDINATION OF BENEFITS PAYABLE. Insurers are urged to use the following claims administration procedures to expedite claim payments where coordination of benefits is involved:

(a) Improving exchange of benefit information;

(b) There should be continued and improved education of claim personnel, stressing accurate and prompt completion of the HIC Duplicate Coverage Inquiry (DUP-1) Form by the inquiring insurer and the responding insurer. This education effort should also be encouraged through local claim associations;

(c) Claim personnel should be encouraged to make every effort, including use of the telephone, to speed up exchange of coordination of benefits information;

(d) Insurers should encourage building a local data file of other group plans in the area, with at least basic information on group health plans for major employers;

(e) Each insurer should establish a time limit after which full or partial payment should be made. When payment of a claim is necessarily delayed for reasons other than the application of a coordination of benefits provision, investigation of other valid coverage should be conducted concurrently so as to create no further delay in the ultimate payment of benefits. Occasionally this will necessitate an insurer making payment as the primary insurer with a right of recovery in the event that subsequent investigation proves that payment as a secondary insurer should have been made.

(15) SMALL CLAIMS WAIVER. Insurers are urged to waive the investigation of possible other coverage for coordination of benefits purposes on claims less than $50, but if additional liability is incurred to raise the small claim above $50, the entire liability may be included in the coordination of benefits computation.

(16) SUBROGATION. The concept of coordination of benefits is clearly distinguishable from that of subrogation. Provisions for either may be included in a group disability insurance policy without compelling the inclusion or exclusion of the other.

(17) EDUCATION OF INSUREDS. Each insurer has an affirmative obligation to urge its respective group clients to take reasonable steps to assure that those insured by the group policy or subscriber contract have been exposed to reasonably concise explanations, with as little technical terminology as is commensurate with accuracy, as to the purpose and operation of coordination of benefits. Such educational effort may take the form of articles in the employer magazines or newspapers, speeches before the appropriate labor organization in the case of a unionized employer, brochures added to pay envelopes, notices on the company bulletin board, materials used by personnel department in counseling employes, and the like.

(18) DISCLOSURE OF COORDINATION OF BENEFIT CLAUSES IN CERTIFICATES OF COVERAGE. Each certificate of coverage under a group disability policy or contract which provides coordination of benefits pursuant to this section shall contain, at least in summary form, a description of the coordination of benefit clauses.

(19) SEVERABILITY. If any provision of this section or its application to any person or circumstances is held invalid, the invalidity does not affect other provisions or applications of the section which can be given effect without the invalid provisions or application, and to this end the parts of this section are declared to be severable.

(20) EFFECTIVE DATE. This section shall become effective on September 1, 1980. The authorized clauses, authorized modifications thereof and the substantive requirements of this section shall apply to all policy and contract forms subject to this section that are issued on or after this effective date. Policies or contracts which are otherwise subject to this section which are in force as of the effective date shall comply with this section by the later of the next anniversary or renewal date of the group policy or contract, or the expiration of the applicable collectively bargained contract pursuant to which they were written, if any.

History: Cr. Register, July, 1980, No. 295, eff. 9-1-80; am. (2), Register, January, 1981, No. 301, eff. 2-1-81.

Ins 3.41 Individual conversion policies. (1) REASONABLY SIMILAR COVERAGE. An insurer provides reasonably similar coverage under s. 632.897 (4), Stats., to a terminated insured as defined in s. 632.897 (1) (f), Stats., if a person is offered individual coverage substantially identical to the terminated coverage under the group policy or individual policy, or is offered his or her choice of the 3 plans described in s. Ins 3.42, Wis. Adm. Code, or is offered a high limit comprehensive plan of benefits approved for the purpose of conversion by the commissioner as meeting the standards described in s. Ins 3.43, Wis. Adm. Code. Individual conversion policies must include benefits required for individual disability insurance policies by subch. VI, ch. 632, Stats.

(2) RENEWABILITY. (a) Except as provided in par. (b), individual conversion policies shall be renewable at the option of the insured unless the insured fails to make timely payment of a required premium amount, there is over-insurance as provided by s. 632.897 (4) (d), Stats., or there was fraud or material misrepresentation in applying for any benefit under the policy.

(b) Conversion policies issued to a former spouse under s. 632.897 (9) (b), Stats., must include renewal provisions at least as favorable to the insured as did the previous coverage.

(3) PREMIUM RATES. (a) In determining the rates for the class of risks to be covered under individual conversion policies, the premium and loss experience of policies issued to meet the requirements of s. 632.897 (4), Stats., may be considered in determining the table of premium rates applicable to the age and class of risks of each person to be covered under the policy and to the type and amount of coverage provided.

(b) Except as provided in par. (c), conditions pertaining to health shall not be an acceptable basis for classification of risks.

(c) A conversion policy issued to a former spouse under s. 632.897 (9) (b), Stats., may be rated on the basis of a health condition if a similar rating had been previously applied to the prior individual coverage due to the same condition.

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

Ins 3.42 Plans of conversion coverage. Pursuant to s. 632.897 (4) (b), Stats., the following plans of conversion coverage are established.

(1) *Plan 1—Basic Coverage*—Plan 1 basic coverage consists of the following:

(a) Hospital room and board daily expense benefits in a maximum dollar amount approximating the average semi-private rate charged in the major metropolitan area of this state, for a maximum duration of 70 days per calendar year;

(b) Miscellaneous in-hospital expenses, including anesthesia services, up to a maximum amount of 20 times the hospital room and board daily expense benefits per calendar year; and

(c) In-hospital and out-of-hospital surgical expenses payable on a usual, customary and reasonable basis up to a maximum benefit of $2,000 a calendar year.

(2) *Plan 2—Major Medical Expense Coverage*—Plan 2 major medical expense coverage shall consist of benefits for hospital, surgical and medical expenses incurred either in or out of a hospital of the following:

(a) A lifetime maximum benefit of $75,000.

(b) Payment of benefits at the rate of 80% of covered medical expenses which are in excess of the deductible, until 20% of such expenses in a benefit period reaches $1,000, after which benefits will be paid at 100% for the remainder of the benefit period; provided, however, benefits for out-patient mental illness, if covered by the policy, may be provide at a lesser rate, but not below 50%, and sugical expenses will be provided at a usual, customary and reasonable level.

(c) A deductible for each benefit period of $500 except that the deductible shall be $1,000 for each benefit period for a policy insuring members of a family. All covered expenses of any insured family member may be applied to satisfy the deductible.

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

(e) Payment for all services covered under the contract by any licensed health care professional qualified to provide the services.

(3) *Plan 3—Major Medical Expense Coverage*—Plan 3 major medical expense coverage shall consist of benefits for hospital, surgical and medical expenses incurred either in or out of a hospital of the following:

(Same as Plan 2 except that maximum benefit is $100,000 and deductible is $1,000 for an individual and $2,000 for a family.)

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

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

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

(b) Payment of benefits at the rate of 80% of covered medical expenses which are in excess of the deductible, until 20% of such expenses in a benefit period reaches $1,000, after which benefits will be paid at 100% for the remainder of the benefit period; provided, however, benefits for out-patient mental illness, if covered by the policy, may be provided at a lesser rate, but not below 50%, and surgical expenses will be provided at a usual, customary and reasonable level.

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

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

(e) Payment for all services covered under the contract by any licensed health care professional qualified to provide the services.

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

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

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

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

(b) A group policy as defined in s. 632.897 (1) (c) 2. shall be considered to have been renewed on any date on which an underlying collective bargaining agreement or other underlying contract is renewed, or on which a significant change is made in benefits.

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

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

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

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