(g) An insurer receiving an application, for a policy as described in par. (a) providing hospital and/or medical expense benefits, from a pregnant applicant or an applicant whose spouse is pregnant, may not issue such a policy to exclude or limit benefits for the expected child. Such a policy must be issued without such an exclusion or limitation, or the application must be declined or postponed.

(h) Coverage is not required for the child born, after termination of the mother's coverage, to a female insured under family coverage who is provided extended coverage for pregnancy expenses incurred in connection with the birth of such child.

(i) A disability insurance policy described in par. (a) shall contain the substance of s. 632.91 (1), (2), (3) and (4), Stats.

(j) Policies issued or renewed on or after November 8, 1975, and before May 5, 1976, shall be administered to comply with s. 204.325, Stats., contained in chapter 98, Laws of 1975. Policies issued or renewed on or after May 5, 1976, and before June 1, 1976, shall be administered to comply with s. 632.91, Stats., contained in chapter 224, Laws of 1975. Policies issued or renewed on or after June 1, 1976, shall be amended to comply with the requirements of s. 632.91, Stats.

History: Cr. Register, February, 1977, No. 254, eff. 3-1-77; reprinted, Register, April, 1977, No. 256, to restore dropped text.

Ins 3.39 Standards for disability insurance sold to the medicare eligible. (1) PURPOSE. (a) This section establishes requirements for health insurance policies sold to Medicare eligible persons as required by the Medicare Catastrophic Act of 1988. Disclosure provisions are required for other disability policies sold to Medicare eligible persons because such policies have frequently been represented to, and purchased by, the Medicare eligible as supplements to Medicare.

(b) This section seeks to reduce abuses and confusion associated with the sale of disability insurance to Medicare eligible persons by providing for reasonable standards. The disclosure requirements and established benefit standards are intended to provide to Medicare eligible persons guidelines that they can use to compare disability insurance policies and certificates and to aid them in the purchase of Medicare supplement and Medicare replacement health insurance which is suitable for their needs. This section is designed not only to improve the ability of the Medicare eligible consumer to make an informed choice when purchasing disability insurance, but also to assure the Medicare eligible persons of this state that the commissioner will not approve a policy or certificate as a "Medicare supplement" or as a "Medicare replacement" unless it meets the requirements of this section.

(c) Wisconsin statutes interpreted and implemented by this rule are ss. 185.983 (1m), 600.03, 601.01 (2), 609.01 (2), 625.16, 628.34 (12), 628.38, 631.20 (2), 632.73 (2m), 632.76 (2) (b) and 632.81.

(2) SCOPE. This section applies to individual and group disability policies sold to Medicare eligible persons as follows:

(a) Except as provided in pars. (d) and (e), this section applies to any group or individual Medicare supplement policy as defined in s. 600.03 (28r), Stats., or any Medicare replacement policy as defined in s. 600.03 (28p), Stats., including:

1. Any Medicare supplement policy or Medicare replacement policy issued by a voluntary sickness care plan subject to ch. 185, Stats.;

2. Any certificate issued under a group Medicare supplement policy or group Medicare replacement policy;

3. Any individual or group policy sold predominantly 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

4. Any conversion contract offered to a Medicare eligible person, if the prior individual or group policy includes no provision inconsistent with the requirements of this section.

(b) Except as provided in pars. (d) and (e), subs. (9) and (11) apply to any individual disability policy sold to a person eligible for Medicare which is not a Medicare supplement or a Medicare replacement policy as described in par. (a).

(c) Except as provided in par. (e), sub. (10) applies to:

1. Any conversion policy which is offered to a person eligible for Medicare as a replacement for prior individual or group hospital or medical coverage, other than a Medicare supplement or a Medicare replacement policy described in par. (a); and

2. Any individual or group hospital or medical policy which continues with changed benefits after the insured becomes eligible for Medicare.

(d) Except as provided in subs. (10) and (13), this section does not apply to:

1. A group policy issued to one or more employers or labor organizations, to the trustees of a fund established by one or more employers or labor organizations, or a combination of both, for employes or former employes or both, or for members or former members or both of the labor organizations;

2. A group policy issued to any professional, trade, or occupational association for its members, former members, retired members, or a combination of these if the association:

a. Is composed of individuals all of whom are or had been actively engaged in the same profession, trade, or occupation;

b. Was maintained in good faith for purposes other than obtaining insurance; and

c. Was in existence for at least 2 years prior to the date of its initial offering of the policy to its members, former members, or retired members;

3. Individual or group hospital, surgical, medical, major medical, or comprehensive medical expense coverage which continues after an insured becomes eligible for Medicare; or

4. A conversion contract offered to a Medicare eligible person as a replacement for prior individual or group hospital, surgical, medical, major medical, or comprehensive medical expense coverage, if the prior policy

includes provisions which are inconsistent with the requirements of this section.

(e) This section does not apply to:

1. A policy providing solely accident, dental, vision, disability income, or credit disability income coverage; or

2. A single premium, non-renewable policy.

(3) DEFINITIONS. In this section:

(a) "Health maintenance organization" means an insurer as defined in s. 609.01 (2), Stats.

(b) "Hospital confinement indemnity coverage" means coverage as defined in s. Ins 3.27 (4) (b) 6.

(c) "Medicare" means the hospital (Part A) and medical (Part B) insurance program established by title XVIII of the federal social security act of 1965, as amended.

(d) "Medicare approved expenses" means health care expenses which are covered by Medicare, recognized as medically necessary and reasonable by Medicare, and which may or may not be fully reimbursed by Medicare.

(e) "Medicare eligible persons" means all persons who qualify for Medicare.

(f) "Medicare replacement coverage" means coverage which meets the definition in s. 600.03 (28p), Stats., as interpreted by sub. (2) (a), and which conforms to subs. (4) and (7).

(g) "Medicare supplement coverage" means coverage which meets the definition in s. 600.03 (28r), Stats., as interpreted by sub. (2) (a), and which conforms to subs. (4), (5) and (6).

(h) "Nursing home coverage" means coverage as described in s. Ins 3.46 (3).

(i) "Outline of coverage" means a printed statement as defined by s. Ins 3.27 (5) (l), which meets the requirements of sub. (4) (b).

(j) "Specified disease coverage" means coverage which is limited to named or defined sickness conditions. The term does not include dental or vision care coverage.

(4) MEDICARE SUPPLEMENT AND MEDICARE REPLACEMENT POLICY AND CERTIFICATE REQUIREMENTS. Except as explicitly allowed by subs. (5) and (7), no disability insurance policy or certificate shall relate its coverage to Medicare or be structured, advertised, or marketed as a Medicare supplement or as a Medicare replacement policy unless:

(a) The policy or certificate:

1. Provides only the coverage set out in sub. (5) or (7) and applicable statutes and contains no exclusions or limitations other than those permitted by sub. (8);

2. Contains no pre-existing condition waiting period longer than 6 months and does not define a pre-existing condition more restrictively

than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage;

3. Contains no definitions of terms such as "skilled nursing facility", "hospital", "nurse", "physician", "Medicare approved expenses", 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, "Medicare", Title XVIII of the Federal Social Security Act of 1965 as Amended";

4. Does not indemnify against losses resulting from sickness on a different basis from losses resulting from accident;

5. Does not, if the policy or certificate is "noncancellable", "guaranteed renewable", or "noncancellable and guaranteed renewable", provide for termination of coverage of a spouse solely because of an event specified for termination of coverage of the insured, other than the nonpayment of premium;

6. Provides that termination of the policy or certificate shall be without prejudice to a continuous loss which commenced while the policy or certificate was in force, although the extension of benefits may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits;

7. Contains a renewal, continuation, or nonrenewal provision, on the first page which satisfies the requirements of s. Ins 3.13 (2) (c), (d) and (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;

8. Changes benefits automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors, although there may be a corresponding modification of premiums in accordance with the policy provisions and ch. 625, Stats.;

9. Prominently discloses any limitations on the choice of providers or geographical area of service;

10. Contains on the first page the designation, printed in 18-point type, and in close conjunction the caption printed in 12-point type, prescribed in sub. (5) or (7);

11. Contains text which is plainly printed in black or blue ink the size of which is uniform and not less than 10-point with a lower-case unspaced alphabet length not less than 120-point;

12. Contains a provision describing the review and appeal procedure for denied claims required by s. 632.84, Stats.; and

13. Is approved by the commissioner.

(b) The outline of coverage for the policy or certificate:

1. Is provided to all applicants at the time application is made and, except in the case of direct response insurance, the insurer obtains written acknowledgement from the applicant that the outline was received;

2. Complies with s. Ins 3.27, including subs. (5) (l) and (9) (u), (v) and (zh) 2 and 4.

3. Is substituted to properly describe the policy or certificate as issued, if the outline provided at the time of application did not properly describe the coverage which was issued. The substituted outline shall accompany the policy or certificate when it is delivered and shall contain the following statement in no less than 12-point type and immediately above the company name: "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application, and the coverage originally applied for has not been issued.";

4. Contains in close conjunction on its first page the designation, printed in a distinctly contrasting color in 24-point type, and the caption, printed in a distinctly contrasting color in 18-point type prescribed in sub. (5) or (7);

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

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

7. Contains a listing giving the coverage designation and rate for the Medicare supplement policy as defined in sub. (5) (c), (e) or (g) and each optional benefit offered as defined in sub. (5) (d), (f), (h) or (i). The outline shall disclose separately any optional benefits included in the base policy; and

8. Is approved by the commissioner along with the policy or certificate form.

(c) Any rider or endorsement added to the policy or certificate:

1. Shall be set forth in the policy or certificate and, if a separate, additional premium is charged in connection with the rider or endorsement, the premium charge shall be set forth in the policy or certificate; and

2. After the date of policy or certificate issue, shall be agreed to in writing signed by the insured, if the rider or endorsement increases benefits or coverage with an accompanying increase in premium during the term of the policy or certificate, unless the increase in benefits or coverage is required by law.

3. Shall only provide coverage as defined in sub. (5) (d), (f), (h) or (i) or provide coverage to meet statutory mandated provisions.

(d) The schedule of benefits page or the first page of the policy or certificate shall contain a listing giving the coverage designation and premium rate in the format shown in sub. (10) of the Appendix.

(e) The anticipated loss ratio for the policy form, that is, the expected percentage of the aggregate amount of premiums collected which will be returned to insureds in the form of aggregate benefits under the policy form:

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 coverage, in accordance with accepted actuarial principles and practices;

2. Is at least 60% in the case of individual policies;

3. Is at least 60% in the case of group policies issued as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising;

4. Is at least 75% in the case of group policies other than those described in subd. 3; and

5. Is approved by the commissioner along with the policy form.

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

1. File such changes on a rate change transmittal form substantially identical to Appendix 4 of ch. Ins 25.

2. Include 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).

(5) AUTHORIZED MEDICARE SUPPLEMENT POLICY AND CERTIFICATE DESIGNATION, CAPTIONS, REQUIRED COVERAGES, AND PERMISSIBLE ADDITIONAL BENEFITS. For a policy or certificate to meet the requirements of sub. (4), it shall contain the authorized designation, caption and required coverage. A health maintenance organization shall place the letters HMO in front of the required designation on any approved Medicare supplement policy. A Medicare supplement policy or certificate shall include:

(a) The designation: MEDICARE SUPPLEMENT INSURANCE.

(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. 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 for policies issued after December 31, 1988, and before January 1, 1990:

1. Upon exhaustion of Medicare hospital inpatient psychiatric coverage, at least 175 days per lifetime for inpatient psychiatric hospital care;

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

3. All Medicare Part A eligible expenses for blood to the extent not covered by Medicare;

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 as required under s. 632.895 (1) and (2), Stats., and s. Ins 3.54.

(d) 1. The following permissible additional coverages for policies issued after December 31, 1988, and before January 1, 1990:

a. The permissible additional coverage in sub. (5) (i).

b. At least 75% of usual and customary charges for outpatient prescription drugs based upon the insurer's determination of usual, customary and reasonable charges in the area in which the expenses are incurred. If included as a rider, the rider shall be designated as: OUTPATIENT PRESCRIPTION DRUG USUAL AND CUSTOMARY CHARGES RIDER.

2. The coverage may be included in the base policy or added to the policy as separate riders or amendments. No other coverages may be part of or attached to a Medicare supplement policy.

(e) The following required coverages for policies issued after December 31, 1989, and before January 1, 1991:

1. The coverages described in par. (c);

2. After the Medicare Part B deductible, all Medicare Part B approved expenses to the extent not paid by Medicare, except outpatient psychiatric care, up to the Medicare Part B catastrophic limit;

3. Coverage for 20% of Medicare approved charges for home IV therapy drugs;

4. Coverage for the copayment amount of Medicare approved charges for immunosuppressive drugs; and

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

(f) 1. The following permissible additional coverages for policies issued after December 31, 1989, before and January 1, 1991:

a. The permissible additional coverages in sub. (5) (i);

b. The deductible for outpatient immunosuppressive and home IV therapy drugs. If issued as a rider, the rider shall be designated as: OUTPATIENT PRESCRIPTION DRUG DEDUCTIBLE RIDER; and

c. Except for home IV therapy and immunosuppressive drugs, at least 75% of the usual, customary and reasonable charges for outpatient prescription drugs based upon the insurer's determination of usual, customary, and reasonable charges in the area in which the expenses are incurred. For Home IV therapy and immunosuppressive drugs, coverage for the difference between Medicare's payment and the usual and customary charges as determined by the company. If included as a rider, the rider shall be designated as: OUTPATIENT PRESCRIPTION DRUG USUAL AND CUSTOMARY CHARGES RIDER.

2. The following coverages may be included in the base policy or added to the policy as separate riders or amendments. No other coverages may be part of or attached to a Medicare supplement policy.

(g) The required coverage for policies issued after December 31, 1990 are the same as those required in sub. (e).

(h) 1. The following permissible additional coverages for policies issued after December 31, 1990:

a. The permissible additional coverages in subs. (5) (i);

b. The Medicare deductible for outpatient prescription drugs. If issued as a rider, the rider shall be designated as: OUTPATIENT PRESCRIPTION DRUG DEDUCTIBLE RIDER; and

c. Usual and customary charges for outpatient prescription drugs after the Medicare outpatient prescription drug deductible. If issued as a rider, the rider shall be designated as: OUTPATIENT PRESCRIPTION DRUG USUAL AND CUSTOMARY CHARGES RIDER.

2. The following coverages may be included in the base policy or added to the policy as separate riders or amendments. No other coverages may be part of or attached to a Medicare supplement policy.

(i) Permissible additional coverage which may be included in a Medicare supplement policy or added to the policy as separate riders or amendments. If these coverages are not included in the basic policy, the insurer shall issue a separate rider for each coverage offered.

1. Coverage for the Medicare Part A hospital deductible. If this benefit is included as a rider, then the rider shall be designated: MEDICARE PART A DEDUCTIBLE RIDER;

2. Coverage for home health care for an aggregate of 365 visits per policy year as required by s. 632.895 (1) and (2). If included as a rider, the rider shall be designated as: ADDITIONAL HOME HEALTH CARE RIDER;

3. Coverage for the Medicare Part B medical deductible. If included as a rider, the rider shall be designated as: MEDICARE PART B DEDUCTIBLE RIDER;

4. Coverage for the difference between Medicare's 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. If included as a rider, the rider shall be designated as: FOREIGN TRAVEL RIDER.

6. Coverage for preventive health care services such as routine physical examinations, immunizations, health screenings, and in-hospital private duty nursing services. If offered, these benefits shall be included in the basic policy.

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

(a) Define those terms in the policy or rider and disclose to the policyholder that the UCR charge may not equal the actual charge, if this is true.

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

(7) AUTHORIZED MEDICARE REPLACEMENT POLICY AND CERTIFICATE DESIGNATION, CAPTIONS AND REQUIRED MINIMUM COVERAGES. For a policy or certificate to meet the requirements of sub. (4), it shall contain the authorized designation, caption and minimum required coverage. A health maintenance organization shall place the letters HMO in front of the required designation on any approved Medicare replacement policy. A Medicare replacement policy or certificate shall include:

(a) The designation: MEDICARE REPLACEMENT INSURANCE;

(b) The caption, except that the word "certificate" may be used instead of "policy", if appropriate: "The Wisconsin Insurance Commissioner has set minimum standards for Medicare replacement insurance. This policy meets these standards. For an explanation of these standards and other important information, see 'Health Insurance Advice for Senior Citizens' given to you when you bought this policy. Do not buy this policy if you did not get this guide."

(c) The following minimum coverage, in addition to Medicare benefits:

1. The Medicare Part A hospital deductible;

2. Upon exhaustion of all Medicare hospital inpatient psychiatric coverage, at least 175 days per lifetime for inpatient psychiatric hospital care;

3. Medicare Part A eligible expenses in a skilled nursing facility to the extent not covered by Medicare subject to a maximum benefit per calendar year of 365 days;

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 as required under s. 632.895 (1) and (2), Stats., and s. Ins 3.54.

(8) PERMISSIBLE MEDICARE SUPPLEMENT AND MEDICARE REPLACEMENT POLICY OR CERTIFICATE EXCLUSIONS AND LIMITATIONS. (a) The coverage set out in subs. (5) and (7):

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

2. May contain an appropriate provision relating to the effect of other insurance on claims;

3. May contain a pre-existing condition waiting period provision as provided in sub. (4) (a) 2., which shall appear as a separate paragraph of the policy and shall be captioned or titled "Pre-existing Condition Limitations"; and

4. May, if issued by a health maintenance organization as defined by s. 609.01 (2), Stats., include territorial limitations which are generally applicable to all coverage issued by the plan.

(b) If the insured chooses not to enroll in Medicare Part B, the insurer may exclude from coverage the expenses which Medicare Part B would have covered if the insured were enrolled in Medicare Part B. An insurer may not exclude Medicare Part B approved expenses incurred beyond what Medicare Part B would cover.

(c) The coverages set out in subs. (5) and (7) may not exclude, limit, or reduce coverage for specifically named or described pre-existing diseases or physical conditions, except as provided in par. (a) 3.

(d) 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.

(e) A Medicare replacement policy may include other policy exclusions and limitations which are not otherwise prohibited.

(9) INDIVIDUAL POLICIES PROVIDING NURSING HOME, HOSPITAL CONFINEMENT INDEMNITY, SPECIFIED DISEASE AND OTHER COVERAGES. (a) Caption requirements. Captions required by this subsection shall be:

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

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

3. Printed in 18-point bold letters.

(b) Nursing home coverage. An individual policy form providing nursing home coverage subject to s. Ins 3.46 which is sold to Medicare-eligible persons shall bear the caption: "This policy's nursing home benefits are not related to Medicare. For more information, see 'Health Insurance Advice for Senior Citizens' given to you when you applied for this policy."

(c) Hospital confinement indemnity coverage. An individual policy form providing hospital confinement indemnity coverage sold to a Medicare eligible person:

1. Shall not include benefits for nursing home confinement unless the nursing home coverage meets the standards set forth in s. Ins 3.46;

2. Shall bear the caption, if the policy provides no other types of coverage: "This policy is not designed to fill the gaps in Medicare. It will pay you only a fixed dollar amount per day when you are confined to a hospital. For more information, see 'Health Insurance Advice for Senior Citizens', given to you when you applied for this policy."

3. Shall bear the caption set forth in par. (e), if the policy provides other types of coverage in addition to the hospital confinement indemnity coverage.

(d) Specified disease coverage. An individual policy form providing benefits only for one or more specified diseases sold to a Medicare eligible person shall bear:

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

2. The caption: "This policy covers only one or more specified or rare illnesses. It is not a substitute for a broader policy which would generally cover any illness or injury. For more information, see 'Health Insurance Advice for Senior Citizens', given to you when you applied for this policy."

(e) Other coverage. An individual disability policy sold to a Medicare eligible person, other than a form subject to subs. (5) and (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."

(10) CONVERSION OR CONTINUATION OF COVERAGE. (a) Conversion requirements. An insured under individual, family, or group hospital or medical coverage who will become eligible for Medicare and is offered a conversion policy which is not subject to subs. (4), (5), and (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:

1. An outline of coverage as described in par. (d) and

2. A copy of the current edition of the pamphlet described in sub. (11).

(b) Continuation requirements. An insured under individual, family, or group hospital or medical coverage who will become eligible for Medicare and whose coverage will continue with changed benefits (e.g., "carve-out" or reduced benefits) shall be furnished by the insurer, within 14 days of a request:

1. A comprehensive written explanation of the coverage to be provided after Medicare eligibility, and

2. A copy of the current edition of the pamphlet described in sub. (11).

(c) Notice to group policyholder. An insurer which provides group hospital or medical coverage shall furnish to each group policyholder:

1. Annual written notice of the availability of the materials described in pars. (a) and (b), where applicable, and

2. Within 14 days of a request, sufficient copies of the same or a similar notice to be distributed to the group members affected.

(d) Outline of coverage. The outline of coverage:

1. For a conversion policy which relates its benefits to or complements Medicare, shall comply with sub. (4) (c) 2., 5. and 7. of this section and shall be submitted to the commissioner; and

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

(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 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.

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

(13) EXEMPTION OF CERTAIN POLICIES AND CERTIFICATES FROM CERTAIN STATUTORY MEDICARE SUPPLEMENT REQUIREMENTS. Policies and certificates defined in sub. (2) (d) of this section, even if they are Medicare supplement policies as defined in s. 600.03 (28r), Stats., or Medicare replacement policies as defined in s. 600.03 (28p), Stats., shall not be subject to:

(a) The special right of return provision for Medicare supplement policies set forth in s. 632.73 (2m), Stats., and s. Ins 3.13 (2) (j) 3; and

(b) The special pre-existing diseases provision for Medicare supplement policies set forth in s. 632.76 (2) (b), Stats.

(14) OTHER REQUIREMENTS. Insurers issuing Medicare supplement policies shall comply with all provisions of Section 4081 of the Omnibus Budget Reconciliation Act of 1987.

History: Cr. Register, July, 1977, No. 259, eff. 11-29-77; am. (13), Register, September, 1977, No. 261, eff. 1-1-78; am. (2), (3) (d), (4) (a) 1., (4) (b) 1. a., 3. e. and 4., (5) (a) 3. a., (5) (b) 3. intro., 3. a., 3. b., (5) (c) 3. a. and b., (5) (d) 3. a., (5) (e) 3. intro. and a., r. and recr. (4) (b) 5., (6), (7), (8) and (9), r. (10), renum. (11) to (13) to be (10) to (12), cr. (4) (b) 6. and 7., Register, December, 1978, No. 276, eff. 1-1-79; am. (4) (b) 1.a., (5) (a) 2. and (b) 2., (5) (c) 2. and (9), r. (5) (d) and (e), Register, April, 1981, No. 304, eff. 5-1-81; r. and recr. (7) (b), Register, May, 1981, No. 305, eff. 6-1-81; r. and recr. Register, June, 1982, No. 318, eff. 7-1-82; renum. (4) (a) 9. to be 10., cr. (4) (a) 9., am. (5) (intro.) and (6) (a) 6., Register, October, 1984, No. 346, eff. 11-1-84; r. (12) under s. 13.93 (2m) (b) 16, Stats., Register, December, 1984, No. 348; am. (1) (a) to (c), (2) (a) (intro.), 1. and 2., (3) (b) and (d), (4) (intro.), (a) 5., 8. and 9., (c) 5., (5) (intro.), (a) 2., (b) 2. and (c) 2., (6) (a) 2. and 3., (9), (11) and Appendix, cr. (3) (dm), (5) (d) and (6) (e), r. (13), Register, November, 1985, No. 359, eff. 1-1-86; cr. (5) (a) 3. i., (b) 3. f., (c) 3. e. and (d) 3. g. Register, April, 1987, No. 376, eff. 6-1-87; emerg. r. and recr. eff. 9-30-88; r. and recr. Register, February, 1989, No. 398, eff. 3-1-89.

APPENDIX

(COMPANY NAME)

OUTLINE OF MEDICARE SUPPLEMENT INSURANCE

or

OUTLINE OF MEDICARE REPLACEMENT INSURANCE

(The designation and caption required by sub. (4) (c) 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) 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) 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) For Medicare supplement policies marketed by intermediaries: Neither (Insert company's name) nor its agents are connected with Medicare.

(b) 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 benefit gaps in Medicare Parts A & B with a parallel description of supplemental benefits, including dollar amounts, as outlined in the attached 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 the attached 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—1989

(This chart may be used for all years)

(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 Calendar Year	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.	Initial ($) deductible	Nothing	Nothing or ($) or ☐ OPTIONAL PART A DEDUCTIBLE RIDER*	
	After initial deductible	100% of costs	Nothing	
Skilled nursing care in a facility approved by Medicare. Confinement must meet Medicare standards.	First 8 days	All but ($) a day	($) a day	
	9th to 150th	100% of costs	Nothing	
	150th to 365th day	Nothing	100% of costs	
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	
Home health care		100% of charges for visits considered medically necessary by Medicare	40 visits or 365 visits or ☐ OPTIONAL ADDITIONAL HOME HEALTH CARE RIDER*	

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

MEDICARE SUPPLEMENT POLICIES—PART B BENEFITS—1989

Medicare Part A 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 ($) deductible	Nothing	Nothing or ($) 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		Nothing, except 80% of approved charges for immuno-suppressive drugs in the first year after a transplant	Nothing or 75% of out-patient prescription drugs or ☐ OPTIONAL OUTPATIENT PRESCRIPTION DRUG USUAL AND CUSTOMARY CHARGES RIDER*	
Part B policy limits per calendar year			$10,000 (or $_____, if greater)	

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

MEDICARE SUPPLEMENT POLICIES—PART B BENEFITS—1990

Medicare Part A Benefits	Per Calendar Year	Medicare Pays	This Policy Pays	You Pay
Medical expenses Eligible expenses for physicians' services, in-patient and out-patient medical services and supplies at a hospital, physical and speech therapy, ambulance and outpatient psychiatric care	Initial ($) deductible	Nothing	Nothing or ($) or ☐ OPTIONAL PART B DEDUCTIBLE RIDER*	
	After initial deductible	80% of Medicare approved charges	20% of Medicare approved charges up to Medicare Part B catastrophic limit of ($)	
		After insured meets catastrophic limit of ($), 100% of Medicare approved charges	Nothing or Difference between Medicare approved charge and usual and customary charge or ☐ OPTIONAL MEDICARE PART B USUAL AND CUSTOMARY RIDER*	

MEDICARE SUPPLEMENT POLICIES—PART B BENEFITS—1990

Medicare Part A Benefits	Per Calendar Year	Medicare Pays	This Policy Pays	You Pay
Immunosuppressive and home IV therapy drugs	Within first year after organ transplant	80% of Medicare approved charges for immuno-suppressive drugs	20% of Medicare approved charges for immuno-suppressive drugs	
	Initial deductible ($)	Nothing	Nothing or ($) deductible or ☐ OUTPATIENT PRESCRIPTION DRUG DEDUCTIBLE RIDER*	
	After initial deductible	50% of Medicare approved charge for immuno-suppressive drugs one year after transplant and beyond	50% of Medicare approved charge for immuno-suppressive drugs	
		80% of Medicare approved charge for home IV therapy drugs	20% of Medicare approved charge home IV therapy drugs	
Other outpatient prescription drugs		Nothing	Nothing or 75% of the out-patient pre-scription drugs or ☐ OPTIONAL OUT-PATIENT PRESCRIPTION DRUG USUAL AND CUSTOMARY RIDER*	
Part B policy limits per calendar year			$10,000 (or $_____, if greater)	

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

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MEDICARE SUPPLEMENT POLICIES—PART B BENEFITS—1991

Medicare Part A 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 ($) deductible	Nothing	Nothing or ($) or ☐ OPTIONAL PART B DEDUCTIBLE RIDER*	
	After initial deductible	80% of Medicare approved charges after you meet catastrophic limit of ($)	20% of Medicare approved charges up to Medicare Part B catastrophic limit of ($)	
		After you meet catastrophic limit of ($), 100% of Medicare approved charges customary charges	Nothing or Difference between Medicare approved and usual and or ☐ OPTIONAL MEDICARE PART B USUAL AND CUSTOMARY RIDER *	

MEDICARE SUPPLEMENT POLICIES—PART B BENEFITS—1991

Medicare Part A Benefits	Per Calendar Year	Medicare Pays	This Policy Pays	You Pay
Immunosuppressive drugs	Within first year after organ transplant	80% of Medicare approved charges for immuno-suppressive drugs	20% of Medicare approved charges for immuno-suppressive drugs	
Other outpatient prescription drugs	Initial ($) deductible	Nothing	Nothing or ($) deductible or ☐ OUTPATIENT PRESCRIPTION DRUG DEDUCT-IBLE RIDER*	
	After initial deductible	80% of Medicare approved charge for home IV therapy drugs and 50% of Medicare charges for all other pre-scription drugs including immuno-suppressive drugs	Nothing except 50% of immuno-suppressive drugs and 20% of Medicare approved charges for home IV therapy drugs or Usual and customary charges for drugs or ☐ OPTIONAL OUTPATIENT PRESCRIPTION DRUG USUAL AND CUSTOMARY RIDER*	
Part B policy limits per calendar year			$10,000 (or $_____, if greater)	

*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 mandate),

(b) Home health care above number of visits covered by Medicare and the 40-visit mandate,

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

(d) Prescription drugs,

(e) Care received outside of U.S.A.,

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

(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.

(6) A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payments of the benefits described in (4) including 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.

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

(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 nonparticipating 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 in the following format:

MEDICARE SUPPLEMENT PREMIUM INFORMATION

Rate

$( ) BASIC MEDICARE SUPPLEMENT POLICY

Note: If any of the optional benefits are included in the basic Medicare Supplement policy, the title and description below must be listed here and not listed as an optional benefit.

OPTIONAL BENEFITS FOR MEDICARE SUPPLEMENT POLICY

Note: Only optional riders available for this Medicare Supplement policy and not included in the basic policy 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.	Outpatient prescription drug deductible None in 1989. The deductible is limited to immunosuppressive and Home IV drugs. In 1991 the deductible applies to all outpatient prescription drugs.
$( )	6.	Usual and customary outpatient prescription drug charges In 1989 and 1990 benefits may be limited to 75%. In 1991 the rider covers the difference between the usual and customary charge and the Medicare-approved charge.
$( )	7.	Foreign travel rider

(12) If premiums for each rating classification are not listed in the outline of coverage under sub (10), then the insurer shall give a separate schedule of premiums for each rating classification with the outline of coverage.

Drafting Note: The term "certificate" should be substituted for the word "policy" throughout the outline of coverage where appropriate. The outline is subject to s. Ins 3.27 (5) (1) and (9) (u), (v) and (zh) 2. and 4.

Ins 3.40 Coordination of benefits provisions in group and blanket disability insurance policies. (1) PURPOSE. (a) This section establishes authorized coordination of benefits provisions for group and blanket disability insurance policies pursuant to s. 631.23, Stats. It has been found that these clauses are necessary to provide certainty of meaning. Regulation of contract forms will be more effective, and litigation will be substantially reduced if there is uniformity regarding coordination of benefits provisions in health insurance policies.

(b) A Coordination of benefits (COB) provision as defined in sub. (3) (e) avoids claim payment delays by establishing an order in which Plans pay their claims and by providing the authority for the orderly transfer of information needed to pay claims promptly. It avoids duplication of benefits by permitting a reduction of the benefits of a Plan when, by the rules established by this section, a Plan does not have to pay its benefits first.

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