(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 minimum requirements for comprehensive health insurance policies sold to Medicare eligible persons. A policy or certificate shall be approved under this section if it provides the required coverage and if it contains the designation and caption appropriate to the type of coverage provided. A policy or certificate that is designed, structured, or intended as a Medicare supplement as defined in s. 600.03 (28r), Stats., shall be disapproved pursuant to s. 631.20, Stats., if that policy does not meet the minimum requirements of any of the 3 levels of coverage for Medicare supplements set out in sub. (5) (a), (b) and (c). A policy or certificate that is designed, structured, or intended as a Medicare replacement policy as defined in s. 600.03 (28p), Stats., shall be disapproved pursuant to s. 631.20, Stats., if it does not meet the requirements set out in sub. (5) (d). Disclosure provisions are also established 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.

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(b) This section seeks to reduce abuses and confusion associated with the sale of disability insurance to Medicare eligible persons by providing for clearly defined categories and reasonable minimum levels of coverage for each category. The disclosure requirements and categories established are intended to provide to Medicare eligible persons guidelines that can be used 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 no policy or certificate will be approved by the commissioner as a "Medicare supplement" or as a "Medicare replacement" unless it meets the requirements of this section.

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(c) Wisconsin statutes interpreted and implemented by this rule are ss. 185.983 (1m), 600.03, 609.01 (2) (as created by 1985 Wisconsin Act 29), 601.01 (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), subs. (4), (5), (6), and (9) apply 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 nonprofit 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 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. (7) and (9) apply to any individual disability policy sold to a person eligible for Medicare which is not a Medicare supplement as described in par. (a).

(c) Except as provided in par. (e), sub. (8) 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 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. (8) and (11), this section does not apply to:

1. A group policy issued to one or more employers or labor organizations, or 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. Has been maintained in good faith for purposes other than obtaining insurance; and

c. Has been 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. For the purpose of this section:

(a) "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; that is, 42 USC 1395 to 1395ss.

(b) "Medicare eligible persons" includes all persons who qualify for Medicare.

(c) "Medicare eligible expenses" means health care expenses of the type covered by Medicare, to the extent recognized as medically necessary by Medicare, and, except as provided in sub. (5) (a) 3 f, to the extent recognized as reasonable by Medicare, which may or may not be fully reimursed by Medicare. "Medicare Part A eligible expenses" means Medicare eligible expenses covered under Medicare Part A, and "Medicare Part B eligible expenses" means Medicare eligible expenses covered under Medicare Part B.

(d) "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).

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

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

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

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

(h) "Outline of coverage" means a printed statement which meets the requirements of s. Ins 3.27 (5) (1), and of sub. (4) (b).

(i) Terms such as "skilled nursing facility" and "benefit period" used in this section shall be as defined by Medicare.

(4) MEDICARE SUPPLEMENT AND MEDICARE REPLACEMENT POLICY AND CERTIFICATE REQUIREMENTS. No disability insurance policy or certificate comprehended by this section shall relate its coverage to Medicare or be structured, advertised, or marketed as a supplement to Medicare or as a Medicare replacement policy unless:

(a) The policy or certificate:

1. Provides at a minimum the coverage set out in sub. (5) and applicable statutes, and contains no exclusions or limitations other than those permitted by sub. (6);

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 eligible expenses", or "benefit period" which are worded less favorably to the insured person than the corresponding Medicare definition, and contains as a definition of the term, "Medicare", "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended", "Title I, Part I of Public Law 39-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import;

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 of the policy or certificate, which satisfies the requirements of s. Ins 3.13 (2) (c), (d) and (e), and clearly states the duration of the term of coverage for which the policy or certificate is issued and for which it may be renewed;

8. Provides that benefits designed to cover cost sharing amounts under Medicare shall be changed 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, and;

10. Is approved by the commissioner.

(b) The policy in the case of an individual policy, or the certificate in the case of a group policy:

1. Contains in close conjunction on its first page the designation, printed in 18-point type of a style in general use, and the caption, printed in 12-point type of a style in general use, prescribed in sub. (5); and

2. Is plainly printed as to text in black or blue ink in type of a style in general use, the size of which is uniform and not less than 10-point with a lower-case unspaced alphabet length not less than 120-point.

(c) 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 (5) (l) and (9) (u), (v) and (zh) 2 and 4.

3. Is substituted so as to properly describe the policy or certificate when it is issued, if the outline provided at the time of application does not properly describe the coverage which was issued, and the substituted outline accompanies the policy or certificate when it is delivered and contains the following statement, in no less than 12-point type, immediatley 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 of a style in general use, and the caption, printed in a distinctly contrasting color in 18-point type of a style in general use, prescribed in sub. (5);

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; and

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

(d) 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.

(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 rates are computed to 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.

(5) AUTHORIZED MEDICARE SUPPLEMENT AND MEDICARE REPLACEMENT POLICY AND CERTIFICATE DESIGNATIONS, CAPTIONS, AND MINIMUM COVERAGES. For a policy or certificate to meet the requirements of sub. (4), it shall contain the authorized designation, caption and minimum coverage prescribed for one of the following categories. A health maintenance organization as defined in s. 609.01 (2), Stats., shall place the letters HMO in front of the required designation on any approved Medicare supplement or Medicare replacement policy.

(a) A MEDICARE SUPPLEMENT 1 policy or certificate shall include:

1. The following designation: MEDICARE SUPPLEMENT 1

2. The following caption, except that the word "certificate" may be used instead of "policy", if appropriate: The Wisconsin Insurance Commissioner has set minimum standards for comprehensive health insurance policies sold to the Medicare eligible. There are two types—Medicare Supplements and Medicare Replacements. A Medicare Supplement 1 is the most comprehensive Medicare Supplement. A Medicare Supplement 3 is the least comprehensive Medicare Supplement. For an explanation of the minimum benefits for Medicare Supplements and Medicare Replacements and a comparison of the two types, see "Health Insurance Advice for Senior Citizens," given to you when you applied for this policy. Do not buy this policy if you did not get this guide.

3. The following minimum coverage: This level of coverage shall at a minimum cover all expenses listed below.

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

b. Medicare Part A eligible expenses for hospitalization, including inpatient psychiatric care, to the extent not covered by Medicare during use of Medicare's lifetime hospital inpatient reserve days;

c. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days or the maximum coverage for inpatient psy-

chiatric care, all Medicare Part A eligible expenses for hospitalization not covered by Medicare, including inpatient psychiatric care, subject to a maximum benefit of at least an additional 365 days per Medicare benefit period;

d. Medicare Part A eligible expenses for extended care services in a skilled nursing facility to the extent not covered by Medicare subject to a maximum benefit per Medicare benefit period of at least 365 days;

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

f. All usual and customary charges for Medicare Part B eligible expenses, except outpatient psychiatric care, to the extent not covered by Medicare regardless of hospital confinement, based upon the insurer's determination of usual and customary charges in the area in which the expenses are incurred, subject to a minimum benefit of at least $7,500 per calendar year;

g. At least 75% of usual and customary charges for prescription drugs based upon the insurer's determination of usual and customary charges in the area in which the expenses are incurred, subject to the $7,500 calendar year maximum benefit for Medicare Part B eligible expenses; and

h. At least 50% of usual and customary charges for outpatient psychiatric treatment expenses, based upon the insurer's determination of usual and customary charges in the area in which the expenses are incurred, up to a lifetime maximum of at least $1,000 which may be applied to the $7,500 calendar year maximum benefit for Medicare Part B eligible expenses.

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

(b) A MEDICARE SUPPLEMENT 2 policy or certificate shall include:

1. The following designation: MEDICARE SUPPLEMENT 2

2. The following caption, except that the word "certificate" may be used instead of "policy", if appropriate: The Wisconsin Insurance Commissioner has set minimum standards for comprehensive health insurance sold to the Medicare eligible. There are two types—Medicare Supplements and Medicare Replacements. A Medicare Supplement 1 is the most comprehensive Medicare Supplement. A Medicare Supplement 3 is the least comprehensive Medicare Supplement. For an explanation of the minimum benefits for Medicare Supplements and Medicare Replacements and a comparison of the two types see "Health Insurance Advice for Senior Citizens," given to you when you applied for this policy. Do not buy this policy if you did not get this guide.

3. The following minimum coverage: This level of coverage shall at a minimum cover all Medicare eligible expenses listed below.

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

b. Medicare Part A eligible expenses for hospitalization, including inpatient psychiatric care, to the extent not covered by Medicare during use of Medicare's lifetime hospital inpatient reserve days;

c. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days or the maximum coverage for inpatient psychiatric care, all Medicare Part A eligible expenses for hospitalization not covered by Medicare, including inpatient psychiatric care, subject to a lifetime maximum benefit of at least an additional 365 days;

d. Medicare Part A eligible expenses for extended care services in a skilled nursing facility to the extent not covered by Medicare subject to a maximum benefit per Medicare benefit period of at least 365 days; and

e. All Medicare Part B eligible expenses, except outpatient psychiatric care, to the extent not covered by Medicare regardless of hospital confinement, subject to a maximum benefit of at least $5,000 per calendar year.

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

(c) A MEDICARE SUPPLEMENT 3 policy or certificate shall include:

1. The following designation: MEDICARE SUPPLEMENT 3

2. The following caption, except that the word "certificate" may be used instead of "policy", if appropriate: The Wisconsin Insurance Commissioner has set minimum standards for comprehensive health insurance sold to the Medicare eligible. There are two types—Medicare Supplements and Medicare Replacements. A Medicare Supplement 1 is the most comprehensive Medicare Supplement. A Medicare Supplement 3 is the least comprehensive Medicare Supplement. For an explanation of the minimum benefits for Medicare Supplements and Medicare Replacements and a comparison of the two types, see "Health Insurance Advice for Senior Citizens," given to you when you applied for this policy. Do not buy this policy if you did not get this guide.

3. The following minimum coverage: This level of coverage shall at a minimum cover all Medicare eligible expenses listed below.

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

b. Medicare Part A eligible expenses for hospitalization, excluding inpatient psychiatric care, to the extent not covered by Medicare during use of Medicare's lifetime hospital inpatient reserve days;

c. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, at least 90% of all Medicare Part A eligible expenses for hospitalization not covered by Medicare, excluding inpatient psychiatric care, subject to a lifetime maximum benefit of at least an additional 365 days; and

d. At least 20% of all Medicare Part B eligible expenses, except outpatient psychiatric care, regardless of hospital confinement, subject to a maximum calendar year out-of-pocket deductible of $200 of such expenses and to a maximum benefit of at least $5,000 per calendar year.

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

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

1. The following designation: MEDICARE REPLACEMENT POLICY;

2. The following caption, except that the word "certificate" may be used instead of "policy", if appropriate: The Wisconsin Insurance Commissioner has set minimum standards for comprehensive health insurance policies sold to the Medicare eligible. There are two types — Medicare supplements and Medicare Replacements. For an explanation of the minimum benefits for Medicare Supplements and Medicare Replacements and a comparison of the two types, see "Health Insurance Advice for Senior Citizens" given to you when you applied for this policy. Do not buy this policy if you did not get this guide.

3. The following minimum coverage: This level of coverage shall at a minimum cover all expenses listed below in addition to basic Medicare benefits.

a. The initial deductible under Medicare Part A;

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

c. Medicare Part A eligible expenses for hospitalization, including inpatient psychiatric care, to the extent not covered by Medicare during use of Medicare's lifetime hospital inpatient reserve days;

d. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days or the maximum coverage for inpatient psychiatric care, all Medicare Part A eligible expenses for hospitalization not covered by Medicare, including inpatient psychiatric care, subject to a lifetime maximum benefit of at least an additional 365 days;

e. Medicare Part A eligible expenses for extended care services in a skilled nursing facility to the extent not covered by Medicare subject to a maximum benefit per Medicare benefit period of at least 365 days; and

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

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

(6) PERMISSIBLE MEDICARE SUPPLEMENT AND MEDICARE REPLACEMENT POLICY OR CERTIFICATE EXCLUSIONS AND LIMITATIONS. (a) The coverage set out in sub. (5) may:

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

2. Except for Medicare replacement policies under sub. (5) (d), exclude coverage for the initial deductibles for Medicare Parts A and B;

3. Include any exclusion or condition contained in Medicare, except that Medicare supplements 1 and 2 and Medicare replacement policies shall cover inhospital treatment of mental illness the same as any other illness;

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

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

6. If issued by a voluntary nonprofit sickness care plan subject to ch. 185, Stats., or a health maintenance organization as defined by s. 628.36 (2m) (a), Stats., include territorial limitations which are generally applicable to all coverage issued by the plan.

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

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

(d) A policy or certificate subject to sub. (5) which provides benefits for "usual", "reasonable", or "customary" charges, or charges described in similar terms, shall contain a definition of the terms and its outline of coverage shall explain the terms.

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

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

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

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

3. Printed in 18-point bold letters.

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

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

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

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

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

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

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

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

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

(f) *Use of terms.* Except as otherwise provided in this subsection, the terms "Medicare Supplement", "Medigap" and words of similar import shall not be used in a policy or in any advertisement or sales presentation for a policy, unless the policy conforms to sub. (4).

(8) CONVERSION OR CONTINUATION OF COVERAGE. (a) *Conversion requirements.* An insured under individual, family, or group hospital or medical coverage who will become eligible for Medicare and is offered a conversion policy which is not subject to subs. (4), (5), and (6) shall be furnished by the insurer, at the time the conversion application is furnished in the case of individual or family coverage or within 14 days of a request in the case of group coverage:

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

2. A copy of the current edition of the pamphlet described in sub. (9).

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

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

2. A copy of the current edition of the pamphlet described in sub. (9).

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

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

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

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

1. For a conversion policy which relates its benefits to or complements Medicare, shall comply with sub. (4) (c) 2., 5. and 6. of this section and shall be submitted to the commissioner; and

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

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

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

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

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

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

History: Cr. Register, July, 1977, No. 259, eff. 11-29-77; am. (13), Register, September, 1977, No. 261, eff. 1-1-78; am. (2), (3) (d), (4) (a) 1., (4) (b) 1. a., 3. e. and 4., (5) (a) 3. a., (5) (b) 3. intro., 3. a., 3. b., (5) (c) 3. a. and b., (5) (d) 3. a., (5) (e) 3. intro. and a., r. and recr. (4)

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

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APPENDIX

(COMPANY NAME)

OUTLINE OF MEDICARE

SUPPLEMENT COVERAGE

or

OUTLINE OF MEDICARE REPLACEMENT COVERAGE

(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. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) (a) A Medicare supplement policy shall contain the following language:

Medicare Supplement Coverage — Policies of this category are designed to supplement Medicare by covering some hospital, medical, and surgical services which are partially covered by Medicare. Coverage is provided for hospital inpatient charges and some physician charges, subject to any deductibles and co-payment provisions which may be in addition to those provided by Medicare, and subject to other limitations which may be set forth in the policy. 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 (delete if such coverage is provided).

(b) A Medicare replacement policy shall contain the following language:

This policy provides basic Medicare hospital and physician benefits. It also includes benefits beyond those provided by Medicare (delete if this is not true). 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. (delete if such coverage is provided)

(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)

(Insurer 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 (insurer).

Ins 3

(4) (a) for Medicare supplement policies, (a brief summary of the major benefit gaps in Mediare Parts A & B with a parallel description of supplemental benefits, including dollar amounts, provided by the Medicare supplement coverage in the following order: described below)

(b) (for Medicare replacement policies, a brief summary of both the basic Medicare benefits in the policy and additional benefits in the order described below.)

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

Service	Benefit	Basic Medicare Coverage	This Policy Pays	You Pay
HOSPITALIZATION . . . semiprivate room and board, general nursing and miscellaneous hospital services and supplies	First 60 days	All but (current deductible amount) a day		
	61st to 90th day			
Includes meals, special care units, drugs, lab tests, diagnostic x-rays, medical supplies, operating and recovery room, anesthesia and rehabilitation services	91st to 150th day	All but (current amount) a day		
	Beyond 150 days	Nothing		
POSTHOSPITAL SKILLED NURSING CARE. . . In a facility approved by Medicare, you must have been in a hospital for at least three days and enter the facility within 30 days after hospital discharge.	First 20 days	100% of costs		
	Additional 80 days	All but (current amount) a day		
	Beyond 100 days	Nothing		
MEDICAL EXPENSE	Physician's services, inpatient and outpatient medical services and supplies at a hospital, physical and speech therapy and ambulance.	80% of reasonable charge [after current deductible]		

(5) (Statement that the policy does or does not cover the following:)

(a) Private duty nursing,

(b) Skilled nursing home care costs (beyond what is covered by Medicare),

(c) Custodial nursing home care costs,

(d) Intermediate nursing home care costs,

(e) Home health care above number of visits covered by Medicare,

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

(g) Drugs (other than prescription drugs furnished during a hospital or skilled nursing facility stay),

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

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

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

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

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

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

(c) (That there are limitations on the choice of providers or the geographical area served, if this is the case.)

(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) (The amount of premium for this policy.)

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