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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 deter-

mining 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: 1-2-56; emerg. am. eff. 6-22-76; am. Register, September, 1976, No. 249, eff. 10-1-76.

Ins 3.08 Municipal bond insurance. (1) PURPOSE. This section implements and interprets ss. 601.42, 611.19 (1), 618.21, 623.03, 623.04, 627.05, 628.34 (2), 632.14, and 632.17, Stats., for the purpose of establishing minimum requirements for the transaction of a type of surety insurance known as municipal bond insurance.

(2) SCOPE. This section shall apply to the underwriting, marketing, rating, accounting and reserving activities of insurers which write municipal bond insurance.

(3) DEFINITIONS. (a) "Annual statement" means the fire and casualty annual statement form specified in s. Ins. 7.01 (5) (a).

(b) "Contingency reserve" means a reserve established for the protection of policyholders covered by policies insuring municipal bonds against the effect of excessive losses occurring during adverse economic cycles.

(c) "Cumulative net liability" means one-third of one percent of the insured unpaid principal and insured unpaid interest covered by in-force policies of municipal bond insurance.

(d) "Municipal bonds" means securities which are issued by or on behalf of or are paid or guaranteed by:

1. Any state, territory or possession of the United States of America;

2. Any political subdivision of any such state, territory or possession; or

3. Any agency, authority or corporate or other instrumentality of any one or more of the foregoing, or which are guaranteed by any of the foregoing.

(e) "Municipal bond insurance" means a type of surety insurance authorized by s. Ins 6.75 (2) (g) which is limited to the guaranteeing of the performance and obligations of municipal bonds.

(f) "Municipal bond insurer" means an insurer which issues municipal bond insurance.

(g) "Total net liability" means the average annual amount due, net of reinsurance, for principal and interest on the insured amount of any one issue of municipal bonds.

(h) "Person" means any individual, corporation for profit or not for profit, association, partnership or any other legal entity.

(i) "Policyholders' surplus" means an insurer's net worth, the difference between its assets and liabilities, as reported in its annual statement.

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

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

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

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

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

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

1. May 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

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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.

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

(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 sub. (5) or (7) or otherwise subject to the caption requirements in this subsection or exempted by sub. (2) (d) or (e), shall bear the caption: "This policy is not a Medicare supplement. For more information, see 'Health Insurance Advice for Senior Citizens', given to you when you applied for this policy."

(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) and (5) or (7) shall be furnished by the insurer, at the time the conversion application is furnished in the case of individual or family coverage or within 14 days of a request in the case of group coverage:

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 Medi-

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

(c) If a group Medicare supplement policy is replaced by another group Medicare supplement policy, the suceeding insurer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any limitation for pre-existing conditions that would have been covered under the group policy being replaced. emerg cr (29) eff. 1-1-91.

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

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; emerg. r. (5) (d) to (h), (8) (d), renum. (3) (a) to be (3) (am), am. (2) (a) 3., (4) (a) 3. and 7., (b) 5., (d), (e) 1. and 5., (g), (5) (c) (intro.), 4. and 5., (i) 4. and 5., (6) (intro.) and (b), (7) (c) 4. and 5., (8) (a) 1. and (e), (9) (e), (10) (a) (intro.) and (d) 2., (11) and (14), r. and recr. (4) (b) 7., and Appendix, cr. (3) (a), (4) (a) 14. and (f), (5) (c) 6. to 10. and (i) 7., (7) (c) 6. to 8. and (d), (15) and (16), Appendix 2 and 3, eff. 12-11-89, except Appendices eff. 1-1-90; emerg. cr. (17) to (19) and am. (5) (c) 4., eff. 1-2-90; r. (5) (d) to (h) and (8) (d), renum. (3) (a) to be (3) (am), am. (2) (a) 3., (4) (a) 2., 3. and 7., (b) 5., (d), (e) 1. and 5., (g) (5) (b), (c) (intro.), 2., 4. and 5., (i) 4. and 5., (6) (intro.) and (b), (7) (c) 4. and 5., (8) (a) 1. and (e), (9) (e), (10) (a) (intro.) and (d) 2., (11) and (14), r. and recr. (4) (b) 7. and Appendices, cr. (3) (a), (4) (a) 14. and (f), (5) (c) 6. to 12. and (i) 7., (7) (c) 6. to 8. and (d), (15) to (28), Appendices 2 to 6, Register, July, 1990, No. 415, eff. 8-1-90.

APPENDIX 1

(COMPANY NAME)
OUTLINE OF MEDICARE SUPPLEMENT INSURANCE
or
OUTLINE OF MEDICARE REPLACEMENT INSURANCE
(The designation and caption required by sub. (4) (b) 4.)

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

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

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

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

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

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

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

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

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

(c) For medicare replacement policies:

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

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

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

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

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Note: The last paragraph may be omitted if the Plan provides only one benefit or may be altered to suit the coverage provided.

ALTERNATIVE 2.

(B) *Reduction in This Plan's Benefits.* The benefits of This Plan will be reduced when the sum of:

(i) the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and

(ii) the benefits that would be payable for the Allowable Expenses under the other Plans in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made,

exceeds the greater of (a) 80% of those Allowable Expenses or (b) the amount of the benefits in (i) above. In that case, the benefits of This Plan will be reduced so that they and the benefits in (ii) above do not total more than the greater of that (a) and (b).

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan."

ALTERNATIVE 3

(B) *Reduction in This Plan's Benefits.* The benefits that would be payable under This Plan in the absence of this COB provision will be reduced by the benefits payable under the other Plans for the expenses covered in whole or in part under This Plan. This applies whether or not claim is made under a Plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an expense incurred and a benefit payable.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan."

(V) RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

Certain facts are needed to apply these COB rules. The [name of insurance company] has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The [name of insurance company] need not tell or get the consent of any person to do this. Each person claiming benefits under This Plan must give the [name of insurance company] any facts it needs to pay the claim.

(VI) FACILITY OF PAYMENT.

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, The [name of insurance company] may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The [name of insurance company] will not have to

pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

(VII) RIGHT OF RECOVERY.

If the amount of the payments made by the [name of insurance company] is more than it should have paid under this COB provision, it may recover the excess from one or more of:

(A) the persons it has paid or for whom it has paid;

(B) insurance companies; or

(C) other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

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, 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. 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 hospital, medical, and surgical expenses which are in excess of the deductible, until 20% of such expenses in a benefit period reaches $1,000, after which benefits shall be paid at 100% for the remainder of the benefit period; provided, however, benefits for outpatient treatment of mental illness, if covered by the policy, may be limited as provided in par. (g), and surgical expenses shall be covered 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; except payment for psychologists' services may be conditioned upon referral or supervision by a physician.

(f) Payment of benefits for maternity, subject to the limitations in pars. (a),(b), and (c), if maternity was covered under the prior policy.

(g) Benefits for outpatient treatment of mental illness, if provided by the policy, may be limited to either of the following coverages at the option of the insurer:

1. At least 50% of usual, customary and reasonable expenses which are in excess of the policy deductible, subject to the policy lifetime maximum.

2. The minimum benefits for group policies described in s. 632.89 (2) (d), Stats.

(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; am. (2) (b) and (e), cr. (2) (f) and (g), Register, October, 1982, No. 322, eff. 11-1-82.

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 hospital, medical, and surgical expenses which are in excess of the deductible, until 20% of such expenses in a benefit period reaches $1,000, after which benefits shall be paid at 100% for the remainder of the benefit period; provided, however, benefits for outpatient treatment of mental illness, if covered by the policy, may be limited as provided in par. (g), and surgical expenses shall be covered 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; except payment for psychologists' services may be conditioned upon referral or supervision by a physician.

(f) Payment of benefits for maternity, subject to the limitations in pars. (a),(b), and (c), if maternity was covered under the prior policy.

(g) Benefits for outpatient treatment of mental illness, if provided by the policy, may be limited to either of the following coverages at the option of the insurer:

1. At least 50% of usual, customary and reasonable expenses which are in excess of the policy deductible, subject to the policy lifetime maximum.

2. The minimum benefits for group policies described in s. 632.89 (2) (d), Stats.

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

History: Cr. Register, April, 1981, No. 304, eff. 5-1-81; am. (1) (b) and (e), cr. (1) (f) and (g), Register, October, 1982, No. 322, eff. 11-1-82.

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 2 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.

Ins 3.46 Standards for nursing home insurance. (1) FINDINGS. Information on file in the office of the commissioner of insurance indicates that those consumers who wish to buy health insurance to cover nursing home and other long term care frequently are not able to choose the policy which is most suitable for their needs because they do not understand the coverage being offered and do not know how long term care insurance fits in with other group and individual health insurance available in the marketplace. The commissioner finds that the adoption of minimum standards and disclosure requirements for nursing home insurance policies will reduce marketing abuses in the sale of nursing home insurance, will help consumers understand what is covered in the policies being offered, and will assist them in comparing the various policies they are offered. The commissioner finds that a nursing home insurance policy which does not meet the minimum standards and disclosures of this section is misleading and deceptive under s. 628.34 (12), Stats., and the advertising and marketing of such a policy constitutes an unfair trade practice under s. 628.34 (11), Stats.

(2) PURPOSE. This section establishes minimum standards and disclosure requirements for insurance which may be sold as nursing home insurance. A policy shall be disapproved pursuant to s. 631.20 (2) (d), Stats., if the policy does not meet the minimum requirements specified in this section.

(3) SCOPE. (a) Except as provided in pars. (b) and (c), this section applies to any individual or group insurance policy or rider which provides coverage primarily for confinement or care in a licensed skilled or intermediate care facility.

(b) This section does not apply to a rider designed specifically to meet the requirements for coverage of skilled nursing care set forth in s. 632.895 (3), Stats.

(c) This section does not apply to 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.

(d) This section also applies to any individual insurance policy issued to a person eligible for Medicare which provides coverage for confinement or care in a licensed skilled or intermediate care facility in addition to providing hospital confinement indemnity coverage as defined in s. Ins 3.27 (4) (b) 6.

(4) DEFINITIONS. For the purpose of this section:

(a) *"Custodial care"* means care which can be performed by persons without professional medical training and which is primarily for the purpose of meeting the personal needs of the patient, including feeding and personal hygiene.

(b) *"Intermediate nursing care"* means basic care including physical, emotional, social and other restorative services under periodic medical supervision. This nursing care requires the skill of the registered nurse in administration, including observation and recording of reactions and symptoms, and supervision of nursing care.

(c) *"Intermediate care facility"* means a facility licensed as an intermediate care facility by the state in which it is located.

(d) *"Irreversible dementia"* means deterioration or loss of intellectual faculties, reasoning power, memory and will due to organic brain disease characterized by confusion, disorientation, apathy and stupor of varying degrees which is not capable of being reversed and from which recovery is impossible.

(e) *"Medicare"* means the hospital and medical insurance program established by title XVIII, 42 USC 1395 to 1395ss, as amended.

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

(g) *"Outline of coverage"* means a document which gives a brief description of benefits in the format prescribed in Appendix 1 to this section and which complies with s. Ins 3.27 (5) (1) and (9) (zh).

(h) *"Skilled nursing care"* means care furnished on a physician's orders which requires the skills of professional personnel such as a registered or a licensed practical nurse and is provided either directly by or under the supervision of these personnel.

(i) *"Skilled care facility"* means a facility licensed as a skilled nursing facility by the state in which it is located.

(5) NURSING HOME INSURANCE POLICY REQUIREMENTS. No insurance policy covered by this section shall be structured, advertised, or marketed as a nursing home insurance policy unless:

(a) The policy provides at a minimum the coverage set out in sub. (6).

(b) The policy for an individual policy and the certificate for a group policy are plainly printed in black or blue ink in a uniform type of a style

in general use, not less than 10 point with a lower case unspaced alphabet length not less than 120 point.

(c) If the policy is sold to Medicare-eligible persons, it meets the requirements of s. Ins 3.39 (7) (a) and (b).

(d)The policy and certificates define skilled and intermediate nursing care no more restrictively than the definitions in this section.

(6) MINIMUM COVERAGES. (a) Except as provided in pars. (b) through (g) of this section, a nursing home policy shall provide coverage for each person insured under the policy for skilled nursing services or intermediate nursing services received while a resident of any licensed skilled care facility or intermediate care facility.

(b) Nursing home policies may limit benefits to a fixed daily benefit. The daily benefit may differ for different levels of care, but the lowest level of daily benefits shall not be less than 50% of the highest level of benefits.

(c) Nursing home policies may provide benefits subject to an elimination period. The elimination shall be expressed in a number of days per lifetime or per period of confinement. However, if an insurer offers a policy with an elimination period of 100 days or more, it must also offer a policy with an elimination period of less than 100 days.

(d) Nursing home policies may provide benefits subject to a lifetime maximum, but the lifetime maximum shall be at least 365 days of coverage.

(e) Nursing home policies shall offer coverage for both skilled and intermediate nursing care.

(f) Nursing home policies are not required to duplicate payments by Medicare for nursing home care.

(g) Nursing home policies may limit coverage to care certified as medically necessary according to generally accepted standards of medical practice and recertified periodically. Insurers shall consider but are not necessarily bound by an attending physician's determination of the level of care the patient is receiving.

(h) Nursing home policies may limit benefits to care received after a hospitalization under the following conditions:

1. Any insurer offering a policy which requires prior hospitalization must also offer an identical policy which does not require a prior hospitalization.

2. The prior hospitalization requirement shall be no more than three days and shall not be applied to any person with irreversible dementia who requires either skilled or intermediate nursing care in a skilled or intermediate care facility and is otherwise eligible for benefits under the policy.

3. The caption described in sub. (8) (d) includes a statement which accurately describes the prior hospitalization requirement.

(i) The following limitations and exclusions are prohibited in nursing home policies.

1. Coverage limiting or excluding benefits for any form of irreversible dementia.

2. Coverage which conditions eligibility for intermediate care benefits on the prior receipt of skilled care benefits.

(7) RENEWABILITY. An insurer may not alter or terminate any policy subject to this section on an individual basis except for nonpayment of premium. The insurer may alter or terminate a policy if it alters or terminates all similar policies on a class basis.

(8) DISCLOSURE REQUIREMENTS. (a) Insurers and intermediaries shall provide to all prospective purchasers of any policy subject to this section an outline of coverage at the time the prospect is first contacted by an intermediary or insurer with an invitation to apply as defined in s. Ins 3.27 (5) (g).

(b) The outline of coverage shall be printed in an easy to read type in language which is easy to understand.

(c) The outline of coverage shall be approved by the commissioner prior to use.

(d) The policy for an individual policy, the certificate for a group policy and the outline of coverage for both shall contain the following caption printed in 12 point type in a style in general use:

The Wisconsin insurance commissioner's office has established minimum standards for nursing home insurance. This policy meets those standards.

This policy covers only certain types of nursing home care. It will not pay for all care in all nursing homes. PLEASE READ YOUR POLICY AND OUTLINE OF COVERAGE CAREFULLY TO BE SURE THAT YOU UNDERSTAND THE BENEFITS.

(e) If the policy is offered to a Medicare eligible person, the outline of coverage shall comply with s. Ins 3.39 (7) (a) and (b).

(9) LOSS RATIO REQUIREMENTS. (a) The anticipated loss ratio shall be at least 55% in the case of individual policies, at least 55% 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, and at least 75% in the case of other group policies.

(b) The loss ratio shall be approved along with the policy form.

(c) The loss ratio shall be 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 guidelines.

Note: Section Ins. 3.46, revised effective January 1, 1987, first applies to policies issued after March 1, 1987.

History: Cr. Register, June, 1981, No. 305, eff. 11-1-81; cr. (3) (c), Register, June, 1982, No. 318, eff. 7-1-82; am. (1) and (3) (b), Register, March, 1985, No. 351, eff. 4-1-85; (6m) deleted under s. 13.93 (2m) (b) 16, Stats., Register, March, 1985, No. 351; r. and recr. Register, December, 1986, No. 372, eff. 1-1-87.

Ins 3.46 Appendix I

(COMPANY NAME)

OUTLINE OF COVERAGE

NURSING HOME INSURANCE POLICY

(The caption required by s. Ins 3.46 (8) (d))

(The caption required by s. Ins 3.39 (7) (a) and (b) if policy is offered to a person eligible for Medicare)

(1) The outline shall contain the following language: 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.

(2) The outline shall contain the following language: This is a Nursing Home Insurance Policy. Policies of this category are designed to pay some of the costs of nursing home care. A policy in this category pays for skilled and intermediate care in a state licensed facility. *This policy will not pay for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing and taking medicine.* (This may be modified to reflect actual benefits in policy).

(3) The outline shall contain a brief description of the benefits in the policy in the format outlined below. Variations in this format to accommodate a particular policy may be permitted.

SCHEDULE OF BENEFITS

Type Of Care	Daily Benefit	Deductible	Maximum ($s and Days)
Skilled Care			
Intermediate Care			
Custodial Care			

(4) The outline shall contain a description of the following items, if applicable:

(a) Pre-existing condition limitations

(b) Waiting periods

(c) Exclusions and limitations in the policy

(d) Prior authorization procedures

(e) Benefit periods in the policy

(f) Renewability provisions of the policy

(g) Conditions for terminating coverage

(h) "Free look" provisions in the policy

(i) Prior hospitalization requirements

(5) The outline shall contain the definitions of skilled nursing care, intermediate nursing and, if applicable, custodial care included in this section.

(6) The outline shall contain a statement that the policy will cover skilled or intermediate care for persons with irreversible dementia if the person is receiving either of these levels of care and is otherwise eligible for benefits.

(7) A complete schedule of current premiums for all classifications and a statement concerning circumstances under which premiums are subject to change.

Ins 3.47 Cancer insurance solicitation. (1) FINDINGS. Information on file in the office of the commissioner of insurance shows that significant misunderstanding exists with respect to cancer insurance. Consumers are not aware of the limitations of cancer insurance and do not know how cancer insurance policies fit in with other health insurance coverage. Many of the sales presentations used in the selling of cancer insurance are confusing, misleading and incomplete and consumers are not getting the information they need to make informed choices. The commissioner of insurance finds that such presentations and sales materials are misleading, deceptive and restrain competition unreasonably as considered by s. 628.34 (12), Stats., and that their continued use without additional information would constitute an unfair trade practice under s. 628.34 (11) and would result in misrepresentation as defined and prohibited in s. 628.34 (1), Stats.

(2) PURPOSE. This section interprets s. 628.34 (12), Stats., relating to unfair trade practices. It requires insurers and intermediaries who sell cancer insurance to give all prospective buyers of cancer insurance a shopper's guide prepared by the national association of insurance commissioners.

(3) SCOPE. This section applies to all individual, group and franchise insurance policies or riders which provide benefits for or are advertised as providing benefits primarily for the treatment of cancer. This section does not apply to solicitations in which the booklet, "Health Insurance Advice for Senior Citizens," is given to applicants as required by s. Ins 3.39.

(4) DEFINITION. "A Shopper's Guide to Cancer Insurance" means the document which contains the language set forth in Appendix I to this section.

(5) DISCLOSURE REQUIREMENTS. (a) Each insurer offering a policy or rider described in sub. (3) shall print, and the insurer and its intermediaries shall provide to all prospective purchasers of any policy or rider subject to this section, a copy of "A Shopper's Guide to Cancer

(12) DISENROLLMENT. (a) The limited service health organization shall clearly disclose in the policy and certificate any circumstances under which the limited service health organization may disenroll an enrollee.

(b) The limited service health organization may disenroll a member from the limited service health organization for the following reasons only:

1. The policyholder has failed to pay required premiums by the end of the grace period.

2. The enrollee has committed acts of physical or verbal abuse which pose a threat to providers or other members of the organization.

3. The enrollee has allowed a nonmember to use the limited service health organization's membership card or has knowingly provided fraudulent information in applying for coverage with the limited service health organization or in receiving services.

4. The enrollee has moved outside of the geographical service area of the organization.

5. The enrollee is unable to establish or maintain a satisfactory provider-patient relationship with the provider responsible for the enrollee's care. Disenrollment of an enrollee for this reason shall be permitted only if the limited service health organization can demonstrate that it provided the enrollee with the opportunity to select an alternate primary care provider, made a reasonable effort to assist the enrollee in establishing a satisfactory provider-patient relationship and informed the enrollee that he or she may file a grievance on this matter.

(c) A limited service health organization that has disenrolled an enrollee for any reason except failure to pay required premiums shall make arrangements to provide similar insurance coverage to the enrollee. In the case of group certificate holders this insurance coverage shall be continued until the person is able to find similar coverage or until the next opportunity to change insurers, whichever comes first. In the case of an enrollee covered on an individual basis, coverage shall be continued until the anniversary date of the policy or for one year, whichever is earlier.

(13) TIME PERIOD FOR REVIEW. In accordance with s. 227.116, Stats., the commissioner shall review and make a determination on an application for a certificate of authority within 60 business days after it has been received.

(14) Subs. (9), (10), (11) and (12) shall apply to all policies issued or renewed on or after January 1, 1987.

Note: Section Ins 3.51 shall not apply to policies issued or renewed before January 1, 1987.

History: Cr. Register, November, 1986, No. 371, eff. 12-1-86; renum. (3) (b) and (10) (c) to be (3) (d) and (10) (f), r. (10) (d), cr. (3) (b) and (c), (10) (c) to (e), (g) and (h), am. (10) (a) and (b), Register, October, 1989, No. 406, eff. 1-1-90; renum. from Ins 3.51, Register, August, 1990, No. 416, eff. 9-1-90.

Ins 3.53 HTLV-III antibody testing. (1) FINDINGS. The commissioner of insurance finds and designates that the series of HTLV-III antibody tests found by the state epidemiologist in a report entitled "Serologic tests for the presence of antibody to human T-lymphotropic virus type III" and dated July 28, 1986, to be medically significant and sufficiently

reliable for detecting the presence of the HTLV-III antibody is also sufficiently reliable for use in the underwriting of individual life, accident and health insurance. The state epidemiologist found that the combination of repeatedly reactive ELISA tests validated by a Western blot assay is highly predictive of a true infection with the HTLV-III virus, also known as the HIV or Human Immunodeficiency Virus. While this series of tests does not indicate that a person has AIDS, the use of this series for underwriting purposes is sufficiently reliable to indicate the presence of infection with the HTLV-III virus.

(2) PURPOSE. This section interprets s. 631.90 (3) (a), Stats., by designating which test or series of tests used to detect the HTLV-III antibody is sufficiently reliable for use in the underwriting of individual life, accident and health insurance policies.

(3) SCOPE. This section applies to any insurer writing individual life, accident and health insurance coverage in Wisconsin. Except as provided in sub. (6) (c), this section does not apply to any insurer writing group life, accident and health insurance coverage in Wisconsin, including group life, accident and health insurance coverage which is individually underwritten.

(4) DEFINITIONS. (a) "Alternate test site" means a human T-lymphotropic virus type III virus antibody counseling and testing facility designated by the state epidemiologist as an alternate test site.

(b) "ELISA" means an enzyme-linked immunosorbent assay serologic test which has been licensed by the federal food and drug administration.

(c) "Health care provider" has the meaning given under s. 146.81 (1), Stats.

(d) "Informed consent for testing or disclosure" has the meaning given under s. 146.025 (1) (d), Stats.

(e) "Informed consent for testing or disclosure form" has the meaning given under s. 146.025 (1) (e), Stats.

(f) "Medical information bureau, inc." means the non-profit Delaware incorporated trade association whose members are life insurance companies and which operates an information exchange on behalf of its members.

(g) "Positive ELISA test" means an ELISA test licensed by the federal food and drug administration, performed in accordance with the manufacturer's specifications and resulting in a single serum or plasma specimen which is reactive, both on an initial testing and on at least one of 2 additional tests of the same specimen.

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(h) "Reactive" as used in par. (g) means a single serum or plasma specimen which has an absorbency that is greater than the manufacturer's recommended cut-off.

(i) "Reactive Western blot assay" means a Western blot assay performed in accordance with standard accepted procedures and resulting in a demonstration of antibody to any of the following proteins:

1. p24 and gp41 in the presence or absence of other bands.

2. p24 and p55 in the presence or absence of other bands.

3. gp41 in the presence or absence of other bands.

(j) "Western blot" means an assay which uses reagents consisting of HTLV-III antigens separated by polyacrylamide-gel electrophoresis which are then transferred to nitro-cellulose paper.

(5) HTLV-III ANTIBODY TESTING. A series of tests consisting of a positive ELISA test and a reactive Western blot assay is sufficiently reliable for use in the underwriting of individual life, accident and health insurance policies.

(6) HTLV-III ANTIBODY TEST RESULTS. (a) Except as provided in par. (b), an insurer may only disclose the results of a test for the presence of an antibody to HTLV-III to one or more of the following persons:

1. The applicant or insured who is tested.

2. The applicant's or insured's health care provider if the applicant or insured provides the insurer with informed consent for testing or disclosure to the health care provider.

3. Such other person as the applicant or insured authorizes through an informed consent for testing or disclosure.

(b) An insurer may disclose the results of a test for the presence of an antibody to HTLV-III to the medical information bureau, inc. only for a series of tests which result in a positive ELISA test and a reactive Western blot assay and only after receiving the informed consent for disclosure from the applicant or insured who undergoes the test. The informed consent for testing or disclosure form shall disclose that the test results may be sent to the medical information bureau, inc.

(c) An insurer may not use or obtain from any source including the medical information bureau, inc., the results of a test for the presence of an antibody to HTLV-III taken by any individual or information on whether a test for the presence of any antibody to HTLV-III has been obtained by any individual who is a member of a group for which the insurer is underwriting group life, accident and health insurance on an individual basis.

(d) An insurer may not require or request any individual to reveal whether the individual has undergone a test for the presence of an antibody to HTLV-III at an alternate test site or the results of such a test.

(e) An insurer which requires any individual to undergo a test for the presence of an antibody to HTLV-III shall provide the individual with an informed consent for testing or disclosure form prior to the time at which the individual undergoes the test. The insurer shall maintain a record of this consent.

(7) HTLV-III ANTIBODY TEST COSTS. An insurer may not require an applicant or insured to undergo a series of HTLV-III antibody tests unless the cost of such tests is borne by the insurer.

History: Cr. Register, May, 1987, No. 377, eff. 6-1-87.

Ins 3.54 Home health care benefits under disability insurance policies. (1) PURPOSE. This section implements and interprets ss. 628.34 (1) and (12), 631.20 and 632.895 (1) and (2), Stats., for the purpose of facilitating the administration of claims for coverage of home health care under disability insurance policies and the review of policy forms. The commissioner of insurance shall disapprove a policy under s. 631.20, Stats., if that policy does not meet the minimum requirements specified in this section.

(2) SCOPE. This section applies to disability insurance policies.

(3) DEFINITIONS. In this section:

(a) "Disability insurance policy" means a disability insurance policy as defined under s. 632.895 (1) (a), Stats., which provides coverage of expenses incurred for in-patient hosptial care.

(b) "Home health aide services" means nonmedical services performed by a home health aide which:

1. Are not required to be performed by a registered nurse or licensed practical nurse; and

2. Primarily aid the patient in performing normal activities of daily living.

(c) "Home care visits" means the period of a visit to provide home care, without limit on the duration of the visit, except each consecutive 4 hours in a 24-hour period of home health aide services is one visit.

(d) "Medically necessary" means that the service or supply is:

1. Required to diagnose or treat an injury or sickness and shall be performed or prescribed by the physician;

2. Consistent with the diagnosis and treatment of the sickness or injury;

3. In accordance with generally accepted standards of medical practice; and

4. Not solely for the convenience of the insured or the physician.

(4) MINIMUM REQUIREMENTS. (a) All disability insurance policies including, but not limited to, medicare supplement or replacement policies, shall provide a minimum of 40 home care visits in a consecutive 12-month period for each person covered under the policy and shall make available coverage for supplemental home care visits as required by s. 632.895 (2) (e), Stats.

(b) An insurer shall review each home care claim under a disability insurance policy and may not deny coverage of a home care claim based solely on medicare's denial of benefits.

(c) An insurer may deny coverage of all or a portion of a home health aide service visit because the visit is not medically necessary, not appro-

priately included in the home care plan or not necessary to prevent or postpone confinement in a hospital or skilled nursing facilility only if:

1. The insurer has a reasonable, and documented factual basis for the determination; and

2. The basis for the determination is communicated to the insured in writing.

(d) In determining whether a home care claim, including a claim for home health aide services, is reimbursable under a disability insurance policy, an insurer may apply claim review criteria to determine that home is an appropriate treatment setting for the patient and that it is not reasonable to expect the patient to obtain medically necessary services or supplies on an outpatient basis, subject to the requirements of s. 632.895 (2) (g), Stats.

(e) An insurer shall disclose and clearly define the home care benefits and limitations in a disability insurance policy, certificate and outline of coverage. An insurer may not use the terms "homebound" or "custodial" in the sections of a policy describing home care benefits, exclusions, limitations, or reductions.

(f) In determining whether a home care claim under a disability insurance policy involves medically necessary part-time or intermittent care, an insurer shall give due consideration to the circumstances of each claimant and may not make arbitrary decisions concerning the number of home care visits within a given period which the insurer will reimburse. An insurer may not deny a claim for home care visits without properly reviewing and giving due consideration to the plan of care established by the attending physician under s. 632.895 (1) (b), Stats. An insurer may use claim review criteria based on the number of home care visits in a period for the purpose of determining whether a more thorough review of a home care claim or plan is conducted.

(g) An insurer may use claim review criteria under par. (d) or (f) only if the criteria and review process do not violate s. Ins 6.11. An insurer shall comply with s. 628.34 (1), Stats., when communicating claim review criteria to applicants, insureds, providers or the public.

Note: Section Ins 3.54 applies to disability insurance policies issued or renewed on or after June 1, 1987.

History: Cr. Register, April, 1976, No. 376, eff. 6-1-87.

Ins 3.55 Benefit appeals under nursing home insurance policies and medicare replacement or supplement policies. (1) PURPOSE. This section implements and interprets s. 632.84, Stats., for the purpose of establishing minimum requirements for the internal procedure for benefit appeals that insurers shall provide in nursing home insurance policies and Medicare replacement or supplement policies. This section also facilitates the review by the commissioner of these policy forms.

(2) SCOPE. This section applies to individual and group nursing home insurance policies and Medicare replacement or supplement policies issued or renewed on or after August 1, 1988. This section does not apply to a health maintenance organization, limited service health organization, or preferred provider plan, as those are defined in s. 609.01, Stats.

(3) DEFINITIONS. In this section:

(a) "Benefit appeal" means a request for further consideration of actions involving the denial of a benefit.

(b) "Denial of a benefit" means any denial of a claim, the application of a limitation or exclusion provision, and any refusal to continue coverage.

(c) "Internal procedure" means the insurer's written procedure for handling benefit appeals.

(d) "Medicare replacement policy" has the meaning given in s. 600.03 (28p), Stats.

(e) "Medicare supplement policy" has the meaning given in s. 600.03 (28r), Stats.

(f) "Nursing home insurance policy" means a policy providing nursing home coverage under s. Ins. 3.46.

(4) MINIMUM REQUIREMENTS. (a) Pursuant to s. 632.84 (2), Stats., an insurer shall include in any nursing home insurance policy and any Medicare replacement or supplement policy an internal procedure for benefit appeals.

(b) The insurer shall provide the policyholder and insured with a written description of the benefit appeals internal procedure at the time the insurer gives notice of the denial of a benefit. The written description shall include the name, address, and phone number of the individual designated by the insurer to be responsible for administering the benefit appeals internal procedure.

(c) An insurer shall describe the benefit appeals internal procedure in every policy, group certificate, and outline of coverage. The description shall include a statement on the following:

1. The insured's right to submit a written request in any form, including supporting material, for review by the insurer of the denial of a benefit under the policy; and

2. The insured's right to receive notification of the disposition of the review within 30 days of the insurer's receipt of the benefit appeal.

(d) An insurer shall retain records pertaining to a benefit appeal filed and the disposition of this appeal for at least 3 years from the date that the insurer files with the commissioner under sub. (5) the annual report in which information concerniing the appeal is reported.

(e) No insurer may impose a time limit for filing a benefit appeal that is less than 3 years from the date the insurer gives notice of the denial of a benefit.

(f) An insurer shall make any internal procedure established pursuant to s. 632.84, Stats., available to the commissioner upon request and in as much detail as the commissioner requests.

(5) REPORTS TO THE COMMISSIONER. An insurer shall report to the commissioner by March 31 of each year a summary of all benefit appeals filed during the previous calendar year and the disposition of these appeals, including:

(a) The name of the individual designated by the insurer to be responsible for administering the benefit appeals internal procedure;

(b) Changes made in the administration of claims as a result of the review of benefit appeals;

(c) For each benefit appeal, the line of coverage;

(d) The date each benefit appeal was filed and, if within the calendar year, subsequently resolved;

(e) The date each benefit appeal carried over from the previous calendar year was resolved;

(f) The nature of each benefit appeal; and

(g) A summary of each benefit appeal resolution.

(6) POLICY DISAPPROVAL. The commissioner shall disapprove a policy under s. 631.20, Stats., if that policy does not meet the minimum requirements specified in this section.

History: Cr. Register, May, 1989, No. 401, eff. 1-1-90.