disclosed if such reduction is not effected prior to the age to or term for which the form is non-cancellable or non-cancellable and guaranteed renewable or if regular benefits are payable at least to the age to or term for which the form is non-cancellable or non-cancellable and guaranteed renewable.) and

c. That benefit payments are subject to an aggregate limit, if applicable.

3. Except as provided above, the term "guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums:

a. Until at least age 50, or

b. In the case of a policy issued after age 44, for at least 5 years from its date of issue, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes.

4. A guaranteed renewable policy form shall disclose, as prominently as and in close conjunction with any prominent use of the term "guaranteed renewable":

a. The age to or term for which the form is guaranteed renewable, if other than lifetime,

b. The age or time at which the form's benefits are reduced, if applicable, (The age or time at which a form's benefits are reduced need not be so disclosed if such reduction is not effected prior to the age to or term for which the form is guaranteed renewable or if regular benefits are payable at least to the age to or term for which the form is guaranteed renewable.)

c. That benefit payments are subject to an aggregate limit, if applicable, and

d. That the applicable premium rates may be changed.

Note: "Prominent use" as referred to in 2. and 4. is considered to include, but is not necessarily limited to, use in titles, brief descriptions, captions, bold-face type, or type larger than that used in the text of the form.

5. The foregoing limitation on the use of the term "non-cancellable" shall also apply to any synonymous term such as "not cancellable" and the limitation on use of the term "guaranteed renewable" shall apply to any synonymous term such as "guaranteed continuable".

6. Nothing herein contained is intended to restrict the development of policies having other guarantees of renewability, or to prevent the accurate description of their terms of renewability or the classification of such policies as guaranteed renewable or non-cancellable for any period during which they may actually be such, provided the terms used to describe them in policy contracts and advertising are not such as may readily be confused with the above terms.

7. The provisions of ss. 632.76 (1), 632.74 and 632.77 (3), Stats., are applicable to non-cancellable or non-cancellable and guaranteed renewable or guaranteed renewable policy forms as herein defined.

(f) Policies issued on a family basis shall clearly set forth the conditions relating to termination of coverage of any family member.

(g) Surgical benefit provisions or schedules shall provide that the benefit for any covered surgical procedure not specifically listed in the schedule and not excluded by the provisions of the policy shall be determined by the company on a basis consistent with the benefit provided for a comparable listed procedure.

(h) A limited policy is one that contains unusual exclusions, limitations, reductions, or conditions of such a restrictive nature that the payments of benefits under such policy are limited in frequency or in amounts. All limited policies shall be so identified by having the words "THIS IS A LIMITED POLICY—READ IT CAREFULLY" imprinted or stamped diagonally across the face of the policy and the filing back, if any, in contrasting color from the text of the policy and in outline type not smaller than 18-point. When appropriate, these words may be varied by the insurer in a manner to indicate the type of policy; as for example, "THIS POLICY IS LIMITED TO AUTOMOBILE ACCIDENTS—READ IT CAREFULLY". Without limiting the general definition above, policies of the following types shall be defined as "limited": 1. School Accident, 2. Aviation Accident, 3. Polio, 4. Specified Disease, 5. Automobile Accident.

(i) If the policy excepts coverage while the insured is in military or naval service, the policy must provide for a refund of pro rata unearned premium upon request of the insured for any period the insured is not covered. However, if coverage is excluded only for loss resulting from military or naval service or war, the refund provision will not be required. This section shall not apply to non-cancellable policies or non-cancellable and guaranteed renewable policies or guaranteed renewable policies.

(j) Except as provided in par. (jm), the provision or notice regarding the right to return the policy required by s. 632.73, Stats., shall:

1. Be printed on or attached to the first page of the policy,

2. Have a caption or title which refers at least to the right to examine or to return the policy such as: "Right to Return Policy Within 10 Days of Receipt", "Notice: Right to Return Policy", "Right of Policy Examination", "Right to Examine Policy", "Right to Examine Policy for 10 Days", "10 Day Right to Examine Policy", "10 Day Right to Return Policy", or "Notice of 10 Day Right to Return Policy", or other wording, subject to approval by the commissioner, which is believed to be equally clear or more definite as to subject matter, and

3. Provide an unrestricted right to return the policy, within 10 days from the date it is received by the policyholder, to the insurer at its home or branch office, if any, or to the agent through whom it was purchased; except it shall provide an unrestricted right to return the policy within 30 days of the date it is received by the policyholder in the case of a Medicare supplement policy subject to s. Ins 3.39 (4), (5), and (6), issued pursuant to a direct response solicitation. Provision shall not be made to require the policyholder to set out in writing the reasons for returning the policy, to require the policyholder to first consult with an agent of the insurer regarding the policy, or to limit the reasons for return.

Note: Paragraph (j) was adopted to assist in the application of s. 204.31 (2) (a), Stats., to the review of accident and sickness policy and other contract forms. Those statutory requirements are presently included in s. 632.73, Stats. The original statute required that the provision of notice regarding the right to return the policy must be appropriately captioned or titled. Since the important rights given the insured are to examine the policy and to return the policy, the rule requires that the caption or title must refer to at least one of these rights—examine or return. Without such reference, the caption or title is not considered appropriate.

The original statute permitted the insured to return the policy for refund to the home office or branch office of the insurer or to the agency with whom it was purchased. In order to assure the refund is made promptly, some insurers prefer to instruct the insured to return the policy to a particular office or agent for a refund. Notices or provisions with such requirements will be approved on the basis that the insurer must recognize an insured's right to receive a full refund if the policy is returned to any other office or agent mentioned in the statute.

Also, the statute permits the insured to return a policy for refund within 10 days from the date of receipt. Some insurers' notices or provisions regarding such right, however, refer to delivery to the insured instead of receipt by the insured or do not specifically provide for the running of the 10 days from the date the insured receives the policy. Notices or provisions containing such wording will be approved on the basis that the insurer will not refuse refund if the insured returns the policy within 10 days from the date of receipt of the policy.

Sections 632.73 (2m) and 600.03 (35) (e), as created by Chapter 82, Laws of 1981, provide for the right of return provisions in certain certificates of group Medicare supplement policies. Therefore, for purposes of this subparagraph, the word policy includes a Medicare supplement certificate subject to Ins 3.39 (4), (5), and (6).

(jm) Medicare replacement policies as defined in s. 600.03 (28p), Stats., are exempt from the provisions of s. 632.73 (2m), Stats., and are subject to the following:

1. Medicare replacement policies shall permit members to disenroll at any time for any reason. Premiums paid for any period of the policy beyond the date of disenrollment shall be refunded to the member on a pro rata basis. A Medicare replacement policy shall include a written provision providing for the right to disenroll which shall:

a. Be printed on or attached to the first page of the policy,

b. Have the following caption or title: "RIGHT TO DISENROLL FROM PLAN".

c. Include the following language or similar language approved by the commissioner:

You may disenroll from the plan at any time for any reason. However, it may take up to 60 days to return you to the regular Medicare program. Your disenrollment will become effective on the day you return to regular Medicare. You will be notified by the plan of the date on which your disenrollment becomes effective. The plan will return any unused premium to you on a pro rata basis.

2. The Medicare replacement policy may require requests for disenrollment to be in writing. Enrollees may not be required to give their reasons for disenrolling, or to consult with an agent or other representative of the insurer before disenrolling.

(k) A policy which contains any provision under which the claimant may elect one benefit in lieu of another shall not limit to a specified period the time within which election may be made.

(3) RIDERS AND ENDORSEMENTS. (a) A rider is an instrument signed by one or more officers of the insurer issuing the same to be attached to and form a part of a policy. All riders shall comply with the requirements of s. 204.31 (2) (a) 4, 1973 Stats.

(b) If the rider reduces or eliminates coverage of the policy, signed acceptance of the rider by the insured is necessary. However, signed acceptance of the rider is not necessary when the rider is attached at the time of the original issuance of the policy if notice of the attachment of the rider is affixed on the face and filing back, if any, in contrasting color, in not less than 12-point type. Such notice shall be worded in one of the following ways:

"Notice! See Elimination Rider Attached"

"Notice! See Exclusion Rider Attached"

"Notice! See Exception Rider Attached"

"Notice! See Limitation Rider Attached"

"Notice! See Reduction Rider Attached"

A company may submit, subject to approval by the commissioner, other wording which it believes is equally clear or more definite as to subject matter.

(c) An endorsement differs from a rider only in that it is applied to a policy by means of printing or stamping on the body of the policy. All endorsements shall comply with the requirements of s. 204.31 (2) (a) 4, 1973 Stats.

(d) If the endorsement reduces or eliminates coverage of the policy, signed acceptance of the endorsement by the insured is necessary. However, signed acceptance of the endorsement is not necessary when the endorsement is affixed at the time of the original issuance of the policy if notice of the endorsement is affixed on the face and filing back, if any, in contrasting color, in not less than 12-point type. Such notice shall be worded in one of the following ways:

"Notice! See Elimination Endorsement Included Herein"

"Notice! See Exclusion Endorsement Included Herein"

"Notice! See Exception Endorsement Included Herein"

"Notice! See Limitation Endorsement Included Herein"

"Notice! See Reduction Endorsement Included Herein"

A company may submit, subject to approval by the commissioner, other wording which it believes is equally clear or more definite as to subject matter.

(4) APPLICATIONS. (a) Application forms shall meet the requirements of s. Ins 3.28 (3).

(b) It shall not be necessary for the applicant to sign a proxy provision as a condition for obtaining insurance. The applicant's signature to the application must be separate and apart from any signature to a proxy provision.

(c) The application form, or the copy of it, attached to a policy shall be plainly printed or reproduced in light-faced type of a style in general use, the size of which shall be uniform and not less than 10-point.

(6) RATE FILINGS. (a) The following must be accompanied by a rate schedule:

1. Policy forms.

2. Rider or endorsement forms which affect the premium rate.

(b) The rate schedule shall bear the insurer's name and shall contain or be accompanied by the following information:

1. The form number or identification symbol of each policy, rider or endorsement to which the rates apply.

2. A schedule of rates including policy fees or rate changes at renewal, if any, variations, if any, based upon age, sex, occupation, or other classification.

3. An indication of the anticipated loss ratio on an earned-incurred basis.

4. Any revision of a rate filing shall be accompanied by a statement of the experience on the form and the anticipated loss ratio on an earned-incurred basis under the revised rate filing.

5. Subdivisions 3 and 4 shall not apply to non-cancellable policies or riders or non-cancellable and guaranteed renewable policies or riders or guaranteed renewable policies or riders.

History: Cr. Register, March, 1958, No. 27; subsections (1), (5), (6) eff. 4-1-58; subsections (2), (3), (4) eff. 5-15-58; am. (2) (c) and cr. (4) (c), Register, March, 1959, No. 39, eff. 4-1-59; am. (2) (e), (6) (b) 3 and 4, Register, November, 1959, No. 47, eff. 12-1-59; am. and renum. (2) (c), (d), (e), (f), (g) and (h); am. (3) and (6) (b) 5, Register, June, 1960, No. 54, eff. 7-1-60; am. (2) (e) 4, Register, November, 1960, No. 59, eff. 12-1-60; r. (2) (j), Register, April, 1963, No. 88, eff. 5-1-63; cr. (2) (j), Register, March, 1964, No. 99, eff. 4-1-64; am. (2) (e) 2 and 4, Register, April, 1964, No. 100, eff. 5-1-64; am. (2) (j) 2.; am. NOTE in (2) (j) 3; Register, March, 1969, No. 159; eff. 4-1-69; cr. (2) (k), Register, June, 1971, No. 186, eff. 7-1-71; am. (4) (a), Register, February, 1974, No. 218, eff. 3-1-74; emerg. am. (1), (2) (e) 7, (2) (j), (3) (a) and (c), eff. 6-22-76; am. (1), (2) (e) 7, (2) (j), (3) (a) and (c), Register, September, 1976, No. 249, eff. 10-1-76; am. (1) and (2) (e) 7, Register, March, 1979, No. 279, eff. 4-1-79; r. (5), Register, January, 1980, No. 289, eff. 2-1-80; am. (2) (j) 3., Register, June, 1982, No. 318, eff. 7-1-82; emerg. am. (2) (j) and cr. (2) (jm), eff. 11-19-85; am. (2) (j) (intro.) and cr. (2) (jm), Register, March, 1986, No. 363, eff. 4-1-86; am. (1), Register, September, 1986, No. 369, eff. 10-1-86.

Ins 3.14 Group accident and sickness insurance. (1) PURPOSE. This rule implements and interprets applicable statutes for the purpose of establishing procedures and requirements to expedite the review and approval of group accident and sickness policies permitted by s. 600.03 (23), Stats. and s. Ins 6.75 (1) (c) or (2) (c).

(3) RATE FILINGS. Schedules of premium rates shall be filed in accordance with the requirements of ch. 601 and s. 631.20, Stats. The schedules of premium rates shall bear the insurer's name and shall identify the coverages to which such rates are applicable.

(4) CERTIFICATES. (a) Each certificate issued to an employe or member of an insured group in connection with a group insurance policy shall include a statement in summary form of the provisions of the group policy relative to:

1. The essential features of the insurance coverage,

2. To whom benefits are payable,

3. Notice or proof of loss,

4. The time for paying benefits, and

5. The time within which suit may be brought.

(5) COVERAGE REQUIREMENTS. (a) Policies issued in accordance with s. 600.03 (23), Stats., shall offer to insure all eligible members of the group or association except any as to whom evidence of insurability is not satisfactory to the insurer. Cancellation of coverage of individual members of the group or association who have not withdrawn participation nor received maximum benefits is not permitted, except that the insurer may terminate or refuse renewal of an individual member who attains a specified age, retires or who ceases to actively engage in the duties of a profession or occupation on a full-time basis or ceases to be an active member of the association or labor union or an employe of the employer, or otherwise ceases to be an eligible member.

(b) Surgical benefit provisions or schedules shall provide that the benefit for any covered surgical procedure not specifically listed in the schedule and not excluded by the provisions of the policy shall be determined by the company on a basis consistent with the benefit provided for a comparable listed procedure.

(c) A policy which contains any provision under which the claimant may elect one benefit in lieu of another shall not limit to a specified period the time within which election may be made.

(6) ELIGIBLE GROUPS. In accordance with s. 600.03 (23), Stats.:

(a) The members of the board of directors of a corporation are eligible to be covered under a group accident and sickness policy issued to such corporation,

(b) The individual members of member organizations of an association, as defined in s. 600.03 (23), Stats., are eligible to be covered under a group accident and sickness policy issued to such association insuring employes of such association and employes of member organizations of such association, and

(c) The individuals supplying raw materials to a single processing plant and the employes of such processing plant are eligible to be covered under a group accident and sickness policy issued to such processing plant.

History: Cr. Register, March, 1958, No. 27; subsections (1), (2), (3), eff. 4-1-58; subsections (4), (5), eff. 5-1-58; renum. (5) to be (5) (a); cr. (5) (b), Register, November, 1959, No. 47, eff. 12-1-59; am. (1) (3), (5) (a) and cr. (6), Register, October, 1961, No. 70, eff. 11-1-61; am. (6), Register, February, 1962, No. 74, eff. 3-1-62; cr. (5) (c), Register, June, 1971, No. 186, eff. 7-1-71; emerg. am. (1), (3), (5) (a), (6) (intro.) and (6) (b), eff. 6-22-76; am. (1), (3), (5) (a), (6) (intro.) and (6) (b), Register, September, 1976, No. 249, eff. 10-1-76; r. (2), Register, January, 1980, No. 289, eff. 2-1-80; am. (1), (5) (a), (6) (intro.) and (b), Register, September, 1986, No. 369, eff. 10-1-86; correction in (5) (a) made under s. 13.93 (2m) (b) 5, Stats., Register, April, 1992, No. 436.

Ins 3.15 Blanket accident and sickness insurance. (1) PURPOSE. This rule implements and interprets applicable statutes for the purpose of establishing procedures and requirements to expedite the review and approval of blanket accident and sickness policies permitted by s. 600.03 (4), Stats. and s. Ins 6.75 (1) (c) or (2) (c).

(3) RATE FILINGS. Schedules of premium rates shall be filed in accordance with the requirements of ch. 601 and s. 631.20, Stats. The schedules

to such policy form. The insurer shall not refuse initial coverage for the newborn if the applicable premium, if any, is paid as required by s. 632.91 (3), Stats. Renewal coverage for a newborn shall not be refused except under a policy which permits individual termination of coverage and only as such policy's provisions permit.

(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. 632.895 (5), 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. 632.895 (5), 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. 632.895 (5), Stats.

History: Cr. Register, February, 1977, No. 254, eff. 3-1-77; reprinted, Register, April, 1977, No. 256, to restore dropped text; corrections in (1) (intro.), (i) and (j), made under s. 13.93 (2m) (b) 7, Stats., Register, April, 1992, No. 436.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. A conversion contract offered to a Medicare eligible person as a replacement for prior individual or group hospital, surgical, medical, major medical, or comprehensive medical expense coverage, if the prior policy includes provisions which are inconsistent with the requirements of this section.

(e) This section does not apply to:

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

2. A single premium, non-renewable policy.

(3) DEFINITIONS. In this section:

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

(af) "Accident," "Accidental Injury" or "Accidental Means" shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

1. The definition shall not be more restrictive than the following: " 'Injury or injuries for which benefits are provided' means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

2. The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law or motor vehicle no-fault plan, unless prohibited by law.

(ag) "Applicant" means:

1. In the case of an individual Medicare supplement policy or subscriber contract, the person who seeks to contract for insurance benefits.

2. In the case of a group Medicare supplement policy or subscriber contract, the proposed certificateholder.

(ah) "Certificate" means any certificate issued under a group Medicare supplement policy, which certificate had been delivered or issued for delivery in this state.

(ai) "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall be defined in relation to its status, facilities and available services.

1. A definition of such a home or facility shall not be more restrictive than one requiring that it:

a. Be operated pursuant to law;

b. Be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;

c. Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

d. Provide continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and

e. Maintain a daily medical record of each patient.

2. The definition of such a home or facility may provide that the term does not include:

a. Any home, facility or part of any home or facility used primarily for rest;

b. A home facility for the care of drug addicts or alcoholics; or

c. A home or facility primarily used for the care and treatment of mental diseases or disorders, or custodial or educational care.

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

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

(bl) "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the joint commission on accreditation of hospitals.

1. The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:

a. Be an institution operated pursuant to law, and;

b. Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which charge is made; and

c. Provide 24 hour nursing service by or under the supervision of registered graduate professional nurses (R.N.s).

2. The definition of the term "hospital" may state that the term does not include:

a. Convalescent homes or convalescent, rest or nursing facilities;

b. Facilities primarily affording custodial, educational or rehabilitative care;

c. Facilities for the aged, drug addicts or alcoholics; or

(c) "Medicare" shall be defined in the policy. "Medicare" may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-87, 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 con-

stituted and any later amendments or substitutes thereof," or words of similar import.

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

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

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

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

(gl) "Mental or nervous disorders" shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, and mental or emotional disease or disorder of any kind.

(gm) "Nurse" may be defined so that the description of nurse is restricted to a type of nurse, such as a registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.). If the word "nurse," "trained nurse" or "registered nurse" is used without specific instruction, then the use of the term requires the insurer to recognize the services of any individual who qualified under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

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

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

(il) "Physician" may be defined by including words such as "duly qualified physician" or "duly licensed physician." The use of such terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when such services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

(im) 1. "Sickness" shall not be defined to be more restrictive than sickness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force.

2. The definition of "sickness" may be further modified to exclude any sickness or disease for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

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

(4) MEDICARE SUPPLEMENT AND MEDICARE REPLACEMENT POLICY AND CERTIFICATE REQUIREMENTS. Except as explicitly allowed by subs. (5) and (7), no disability insurance policy or certificate shall relate its cover-

age to Medicare or be structured, advertised, or marketed as a Medicare supplement or as a Medicare replacement policy unless:

(a) The policy or certificate:

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

2. Discloses on the first page any applicable pre-existing conditions limitation, 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 "Medicare eligible expenses," "accident," "sickness," "mental or nervous disorders," "skilled nursing facility," "hospital," "nurse," "physician," "Medicare approved expenses," "benefit period," or "outpatient prescription drugs" which are worded less favorably to the insured person than the corresponding Medicare definition or the definitions contained in sub. (3), and defines "Medicare" as in accordance with sub. (3) (c);

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

5. Is "guaranteed renewable" and does not 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. The policy shall not be cancelled or nonrenewed by the insurer on the grounds of deterioration of health. The policy may be cancelled for nonpayment of premium or material misrepresentation. If the policy is issued by a health maintenance organization as defined by s. 609.01 (2), Stats., the policy may, in addition to the above reasons, be cancelled or nonrenewed by the insurer if the insured moves out of the service area;

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

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

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

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

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

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

13. Is approved by the commissioner.

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

15. Provides for midterm cancellation at the request of the insured and that, if an insured cancels a policy midterm or the policy terminates midterm because of the insured's death, the insurer shall issue a pro rata refund to the insured or the insured's estate.

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) The schedule of benefits page or the first page of the policy or certificate contains a listing giving the coverages and both the annual premium in the format shown in sub. (11) of Appendix 1 and modal premium selected by the applicant.

(e) The anticipated loss ratio for any new 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 for the entire period for which the policy form provides coverage, in accordance with accepted actuarial principles and practices;

2. Complies with the loss ratio standards in sub. (16) (d);

3. Is submitted to the commissioner along with the policy form.

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

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

1. Files such changes on a rate change transmittal form in a format specified by the commissioner.

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

(4m) OPEN ENROLLMENT. Unless the coverage is subject to sub. (7), an insurer may not deny or condition the issuance or effectiveness of, or discriminate in the pricing of, Basic Medicare supplement coverage for which an application is submitted during the 6-month period beginning with the first month in which an individual 65 years of age or older first enrolled for benefits under Medicare Part B on any of the following grounds:

(a) Health status.

(b) Claims experience.

(c) Receipt of health care.

(d) Medical condition.

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

(a) The designation: MEDICARE SUPPLEMENT INSURANCE.

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

(c) The following required coverages, to be referred to as "Basic Medicare Supplement coverage" for a policy issued after December 31, 1990:

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

2. Medicare Part A eligible expenses in a skilled nursing facility for the copayments for the 21st through the 100th day;

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

4. All Medicare Part B eligible expenses to the extent not paid by Medicare, including outpatient psychiatric care, subject to the Medicare Part B calendar year deductible;

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

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

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

8. Payment in full for all usual and customary expenses for chiropractic services required by s. 632.87 (3), Stats. Insurers are not required to duplicate benefits paid by Medicare;

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

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

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

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

13. Payment in full for all usual and customary expenses for treatment of diabetes required by s. 632.895 (6), Stats. Insurers are not required to duplicate expenses paid by Medicare.

(i) Permissible additional coverage which may be added to the policy as separate riders or amendments. The insurer shall issue a separate rider for each coverage the insurer chooses to offer and each rider shall be priced separately and available for purchase separately.

1. Coverage for the Medicare Part A hospital deductible. The rider shall be designated: MEDICARE PART A DEDUCTIBLE RIDER;

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

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

4. Coverage for the difference between Medicare's Part B eligible charges and the amount charged by the provider which shall be no greater than the actual charge or the limiting charge allowed by Medicare. The rider shall be designated as: MEDICARE PART B EXCESS CHARGES RIDER;

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

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

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

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

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

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

(7) AUTHORIZED MEDICARE REPLACEMENT POLICY AND CERTIFICATE DESIGNATION, CAPTIONS AND REQUIRED MINIMUM COVERAGES. (a) A policy form issued by an insurer who has a cost contract with Health Care Financing Administration for Medicare Part B benefits shall meet the standards and requirements of subs. (4) and (5), except that the commissioner may, at the request of an insurer, approve variations of the coverages specified under sub. (5).

(b) For a Medicare replacement policy or certificate, other than a policy subject to par. (a), to meet the requirements of sub. (4), it shall contain the authorized designation, caption and minimum required coverage. A health maintenance organization shall place the letters HMO in front of the required designation on any approved Medicare replacement policy. A Medicare replacement policy or certificate shall include:

1. The designation: MEDICARE REPLACEMENT INSURANCE;

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

3. The following minimum coverage, in addition to Medicare benefits:

a. The Medicare Part A hospital deductible;

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

c. Medicare Part A eligible expenses in a skilled nursing facility for the copayments for the 21st through the 100th day;

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

e. 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;

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

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

h. Payment in full for all usual and customary expenses for chiropractic services required by s. 632.87 (3), Stats. Insurers are not required to duplicate payments made by Medicare;

i. Payment in full for all usual and customary expenses for treatment of diabetes required by s. 632.895 (6), Stats. Insurers are not required to duplicate payments made by Medicare;

(c) Each insurer which markets a Medicare replacement policy shall have an approved Medicare supplement insurance policy available for all currently enrolled participants at the time as the 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 on the first page of the policy and shall be captioned or titled "Pre-existing Condition Limitations;" and

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

5. May exclude coverage for the treatment of service related conditions for members or ex-members of the armed forces by any military or veterans hospital or soldier home or any hospital contracted for or operated by any national government or agency.

(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 eligible 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.

(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 hospi-

tal. 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 Medicare and whose coverage will continue with changed benefits (e.g., "carve-out" or reduced benefits) shall be furnished by the insurer, within 14 days of a request:

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

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

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

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

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

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

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

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

(11) "HEALTH INSURANCE ADVICE FOR SENIOR CITIZENS" PAMPHLET. Every prospective Medicare eligible purchaser of any policy or certificate subject to this section which provides hospital or medical coverage, other than incidentally, or of any coverage added to an existing Medicare supplement policy or certificate, except any policy subject to s. Ins. 3.46, shall receive a copy of the current edition of the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" at the time the prospect is contacted by an intermediary or insurer with an invitation to apply as defined in s. Ins 3.27 (5) (g). Except in the case of direct response insurance, written acknowledgement of receipt of this pamphlet shall be obtained by the insurer. This pamphlet 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 may be periodically revised to reflect changes in Medicare and any other appropriate changes. No insurer shall be responsible for providing applicants the revised pamphlet until 30 days after the insurer has been given notice that the revised pamphlet is available.

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

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

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

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

(14) OTHER REQUIREMENTS. (a) Each insurer may file and utilize only one individual Medicare supplement policy form, one individual Medicare replacement policy form and one group Medicare supplement policy form with any of the accompanying riders permitted in sub. (5) (i), unless the commissioner approves the use of additional forms and the insurer agrees to aggregate experience for the various forms in calculating rates and loss ratios.

(b) An insurer shall mail any refund or return of premium directly to the insured and may not require or permit delivery by an agent or other representative.

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

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

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

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

1. For the most recent year, the ratio of the incurred losses to earned premiums for policies or certificates which have been in force for 3 years or more is greater than or equal to the applicable percentages under par. (d); and

2. The expected losses in relation to premiums over the entire period for which the policy is rated comply with the requirements of par. (d). An expected 3rd-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than 3 years.

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

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

b. Every insurer providing Medicare supplement insurance or benefits to a resident of this state shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or contract as will conform with minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the insurer for such Medicare supplement insurance policies or contracts. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described

herein should be made with respect to a policy at any time other than upon its renewal date or anniversary date. Premiums adjustments shall be in the form of refunds or premium credits and shall be made no later than upon renewal if a credit is given, or within 60 days of the renewal date or anniversary date if a refund is provided to the premium payer. Premium adjustments shall be calculated for the period commencing with Medicare benefit changes.

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

(d) For purposes of sub. (4) (e) and par. (b), the loss ratio standards shall be:

1. At least 65% in the case of individual policies.

2. At least 75% in the case of group policies.

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

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

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

(18) NOTICE REQUIREMENTS TO EXISTING POLICYHOLDERS. (a) No later than January 31, 1990, every insurer providing Medicare supplement insurance or benefits to a resident of this state shall notify its policyholders, contractholders and certificateholders of modifications it has made to its Medicare supplement insurance policies or contracts. Such notice shall be in the format shown in Appendix 4 and shall:

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

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

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

4. Not contain or be accompanied by any solicitation.

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

(19) FORM AND RATE FILING REQUIREMENTS FOR EXISTING POLICIES. (a) Every insurer providing Medicare supplement insurance or contracts

in this state shall file with the commissioner, in accordance with the applicable filing procedures of this state:

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

2. Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement insurance modifications necessary to eliminate benefit duplications with Medicare and to provide the benefits required by this section prior to January 15, 1990. Any such riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or contract.

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

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

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

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

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

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

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

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

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

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

(21) COMMISSION LIMITATIONS. (a) An insurer may provide and an agent or other representative may accept commission or other compensation for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is at least 100% and no more than 150% of the commission or other compensation paid for selling or servicing the policy or certificate in the 2nd year.

(b) The commission or other compensation provided in subsequent renewal years shall be the same as that provided in the 2nd year or period and shall be provided for at least 5 renewal years.

(c) If an existing policy or certificate is replaced, no entity may provide compensation to its producers and no agent or producer may receive compensation greater than the renewal compensation payable by the replacing insurer on the policy or certificate.

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

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

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

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

(d) If a Medicare supplement policy contains any limitations with respect to pre-existing conditions, such limitations must appear on the first page.

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

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

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

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

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

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

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

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

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

a. If so, with which company?

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

3. Are you covered by Medicaid?

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

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

1. Any policy sold which is still in force.

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

(c) Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of accident and sickness coverage. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the insurer. A direct response insurer shall deliver to the applicant at the time of the solicitation of the policy the notice regarding replacement of accident and sickness coverage.

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

(24) STANDARDS FOR MARKETING. (a) Every insurer marketing Medicare supplement insurance coverage in this state, directly or through its producers, shall:

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

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

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

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

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

1. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

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

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

(d) Every insurer shall establish marketing procedures which set forth a mechanism or formula for determining whether a replacement policy or certificate contains benefits clearly and substantially greater than the benefits under the replaced policy.

(e) In regards to any transaction involving a Medicare supplement policy, no person subject to regulation under chs. 600 to 655, Stats., may

knowingly prevent or dissuade or attempt to prevent or dissuade, any person from:

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

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

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

(f) If an insured exercises the right to return a policy during the free look period, the insurer shall mail the entire premium refund directly to the person who paid the premium.

(25) APPROPRIATENESS OF RECOMMENDED PURCHASE AND EXCESSIVE INSURANCE. (a) In recommending the purchase or replacement of any Medicare supplement policy or certificate, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

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

(c) An agent shall foward each application taken for a Medicare supplement policy to the insurer within 7 calendar days after taking the application. An agent shall mail the portion of any premium collected due the insurer to the insurer within 7 days after receiving the premium.

(26) REPORTING OF MULTIPLE POLICIES. (a) On or before March 1 of each year, every insurer providing Medicare supplement insurance coverage in this state shall report the following information for every individual resident of this state for which the insurer has in force more than one Medicare supplement insurance policy or certificate:

1. Policy and certificate number, and

2. Date of issuance.

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

(27) WAITING PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing insurer shall waive any time periods applicable to pre-existing condition waiting periods in the new Medicare supplement policy for similar benefits to the extent time was satisfied under the original policy.

(28) GROUP POLICY CONTINUATION AND CONVERSION REQUIREMENTS. (a) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in par. (c), the insurer shall offer certificateholders at least the following choices:

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

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

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

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

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

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

(29) Every insurer of group Medicare supplement insurance benefits to a resident of this state shall file a copy of the master policy and any certificate used in this state in accordance with the filing requirements and procedures applicable to group Medicare supplement policies issued in this state; provided, however, that no insurer shall be required to make a filing earlier than 30 days after insurance was provided to a resident of this state under a master policy issued for delivery outside this state.

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.

Note: Section (4m), (5) (c) 8 and 13 and (i) (intro.), 1 to 5 and 7, (7) (except (7) (c) 3, as renumbered), and, (16) (a), (b), and (d), as affected by Register No. 427, first apply to policies issued on or after January 1, 1992.

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; emerg. cr. (3) (af) to (aj), (bl), (gl), (gm), (il), (im), (14) (a), (16) (d) and (29), r. and recr. (3) (c), am. (3) (d), (4) (a) 3. and 5., (e), (5) (c) 2., (7) (c) 3., (8) (a) 3., (16) (a) and (b), (21) (a) to (c), (23) (c) and (d), renum. (14) (intro.) to be (14) (b), eff. 1-1-91; r. (9) (b), Register, April, 1991, No. 424, eff. 6-1-91; cr. (3) (af) to (ai), (bl), (gl), (gm), (il) and (im), (4) (a) 15 and (e) 2, (4m), (5) (c) 13, (7) (a) and (b) 3. h and i, (8) (a) 5, (14) (a) and (b), (16) (d), (24) (f), (25) (c) and (29), am. (3) (d), (4) (a) 3, 5 and 7, (4) (e) (intro.) and (f), (5) (c) (intro.), 2 and 4, (5) (i) (intro.), 1 to 5 and 7, (8) (a) 3 and (b), (11), (16) (a) and (b), (21) (a) to (c), (23) (c), (24) (a) (intro.) and (d), (26) (a) (intro.) and (28) (a) (intro.) and (c), r. and recr. (3) (c), (5) (c) 8 and Appendix 1, renum. (4) (e) 5 to be (4) (e) 3, (7) (intro.) to be (7) (b) (intro.) and am., (7) (a), (b) and (c) (intro.) and 1 to 7 to be (7) (b) 1, 2, and 3 (intro.) and a to g, and am. (7) (b) 3. c and d, (7) (d) to be (7) (c) and am., (14) to be (14) (c) and (27) (a) to be (27), r. (4) (e) 2 to 4 and (7) (c) 8, Register, July, 1991, No. 427, eff. 8-1-91.

Ins 3.39 Appendix I

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

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

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

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

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

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

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

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

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

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

(c) For Medicare replacement policies:

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

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

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

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

MEDICARE SUPPLEMENT POLICIES—PART A BENEFITS

(Insurers should include only the wording which applies to their policy's "This Policy Pays" column and complete the "You Pay" column)

Medicare Part A Benefits	Per Benefit Period	Medicare Pays	This Policy Pays	You Pay
Hospitalization. Semiprivate room and board, general nursing and miscellaneous hospital services and supplies. Includes meals, special care units, drugs, lab tests, diagnostic x-rays, medical supplies, operating and recovery room, anesthesia and rehabilitation services.	First 60 days	All but $(current deductible)	$0 or ($) or ☐ OPTIONAL PART A DEDUCTIBLE RIDER*	
	61st to 90th days	All but $(current amount per day)	$(current amount per day)	
	91st to 150th days	All but $(current amount per day)	$(current amount per day)	
	Beyond 150 days	Nothing	All	
Skilled nursing care in a facility approved by Medicare. Confinement must meet Medicare standards. You must have been in a hospital for at least three days and enter the facility within 30 days after discharge.	First 20 days	100% of costs	$0	
	Additional 80 days	All but $(current amount per day)	$(current amount per day)	
Inpatient psychiatric care in a participating psychiatric hospital		190 days per lifetime	175 additional days per lifetime	
Blood		All but 1st 3 pints	First 3 pints	
Home health care		100% of charges for visits considered medically necessary by Medicare	40 visits or 365 visits or ☐ OPTIONAL ADDITIONAL HOME HEALTH CARE RIDER*	

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

MEDICARE SUPPLEMENT POLICIES—PART B BENEFITS

Medicare Part B Benefits	Per Calendar Year	Medicare Pays	This Policy Pays	You Pay
Medical expenses. Eligible expenses for physician's services, inpatient and outpatient medical services and supplies at a hospital, physical and speech therapy, ambulance, and outpatient psychiatric care	Initial ($) deductible	$0	Nothing or ($) or □ OPTIONAL PART B DEDUCTIBLE RIDER*	
	After initial deductible	80% of Medicare approved charge	20% of Medicare approved charge or The difference between what Medicare pays and the excess charge or □ OPTIONAL MEDICARE PART B EXCESS CHARGES RIDER*	
Outpatient prescription drugs		$0	$0 or 75% of outpatient prescription drugs with a deductible of $ ___ (not more than $100) or □ OPTIONAL OUTPATIENT PRESCRIPTION DRUG USUAL AND CUSTOMARY CHARGES RIDER*	
Blood		80% of costs except nonreplacement fees (blood deductible) for first 3 pints (after $ ___ deductible/ calendar year)	20% of all costs and the first 3 pints in each calendar year	
Immunosuppressive drugs		80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant (after $ ___ deductible/ calendar year)	20% of allowable charges for immunosuppressive drugs	
Part B policy limits per calendar year			No limit	

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

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

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

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

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

(d) Outpatient prescription drugs.

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

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

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

(h) Waiting period for pre-existing conditions.

(i) Limitations on the choice of providers or the geographical area served (if applicable).

(j) Usual, customary, and reasonable limitations.

(6) Conspicuous statements as follows:

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

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

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

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

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

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

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

MEDICARE SUPPLEMENT PREMIUM INFORMATION

Annual Premium

$( ) BASIC MEDICARE SUPPLEMENT POLICY

OPTIONAL BENEFITS FOR MEDICARE SUPPLEMENT POLICY

Each of these riders may be purchased separately.

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

$( ) 1. Part A deductible
100% of Part A deductible

$( ) 2. Additional home health care
An aggregate of 365 visits per year including those covered by Medicare

$( ) 3. Part B deductible
100% of Part B deductible

$( ) 4. Part B excess charges

Difference between what Medicare pays and the amount charged by the provider which shall be no greater than the actual charge or the limiting charge allowed by Medicare, whichever is less

$( ) 5. Usual and customary outpatient prescription drug charges
75% of the usual and customary charges after a deductible of $ ____ (no more than $100)

$( ) 6. Foreign travel rider
After a deductable not greater than $250, covers at least 80% of expenses associated with medical care received outside the U.S.A. for a minimum of 30 days

$( ) TOTAL FOR BASIC POLICY AND SELECTED OPTIONAL BENEFITS

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

IN ADDITION TO THIS OUTLINE OF COVERAGE, [INSURANCE COMPANY] WILL SEND AN ANNUAL NOTICE TO YOU 30 DAYS PRIOR TO THE EFFECTIVE DATE OF MEDICARE CHANGES WHICH WILL DESCRIBE THESE CHANGES AND THE CHANGES IN YOUR MEDICARE SUPPLEMENT COVERAGE.

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

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

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

Ins 3.39 Appendix 2

ADVERTISING
CERTIFICATE OF COMPLIANCE

I, _____ (name), an offer of

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

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

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

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

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

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

_____
(signature)

_____
(title)

_____
(date)

Individual responsible for this filing:

Name: _____ Title: _____

Address: _____

Phone Number: _____ Date: _____

Ins 3.39 Appendix 3

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

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

ADVERTISING FORM TRANSMITTAL

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

1. Company OCI Number □□ - □□□□ □□□ - □
1a. Agent OCI License Number □□□□□□□

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

3. Company/Agent Name and Mailing address

4. Individual Responsible for This filing

5. Telephone Number

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

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

11. □ Certificate of Compliance — Ref. Ins 3.39 (15)

OCI 26-16 (08-88)

Ins 3.39 Appendix 4

(COMPANY NAME)

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

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

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

SERVICES	MEDICARE BENEFITS		YOUR MEDICARE SUPPLEMENT COVERAGE	
	In 1989 Medicare Pays Per Benefit Period	Effective January 1, 1990, Medicare Will Pay	In 1989 Your Coverage Pays	Effective January 1, 1990, Your Coverage Will Pay Per Calendar Year
MEDICARE PART A SERVICES AND SUPPLIES				
In patient Hospital Services	Unlimited number of hospital days after $560 deductible	All but $592 for the first 60 days/ benefit period		
Semi-Private Room & Board		All but $148 a day for 61st-90th days/benefit period		
Misc. Hospital Services & Supplies, such as Drugs, X-Rays, Lab Tests & Operating Room		All but $296 a day for 91st-150th days (if individual chooses to use 60 nonrenewable lifetime reserve days)		
BLOOD	Pays all costs except payment of deductible (equal to costs for first 3 pints) each calendar year. Part A blood deductible reduced to the extent paid under Part B	pays all costs except nonreplacement fees (blood deductible) for first 3 pints of each benefit period		
SKILLED NURSING FACILITY CARE	There is no prior confinement requirement for this benefit	100% of costs for 1st 20 days (after a 3-day period hospital confinement)/ benefit period		
	First 8 days - all but $25.50 a day	All but $74.00 a day for 21st-100th days/benefit period		

Ins 3.39 Appendix 3

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

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

ADVERTISING FORM TRANSMITTAL

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

1. Company OCI Number □□ - □□□□ □□□ - □
1a. Agent OCI License Number □□□□□□□

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

3. Company/Agent Name and Mailing address

4. Individual Responsible for This filing

5. Telephone Number

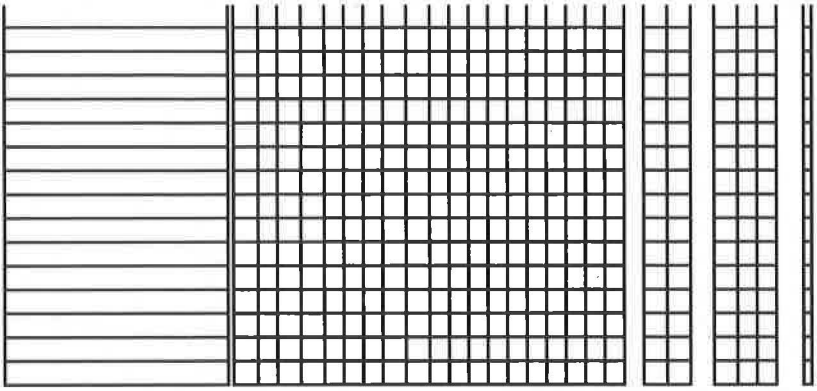
6. Advertisement Title

7. Form Number [s. Ins 3.27 (26)]

8. Coverage Class (Numeric)

9. Code (Alpha)

10. Type of Advertising (Alpha)



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

11. □ Certificate of Compliance — Ref. Ins 3.39 (15)

OCI 26-16 (08-88)

SERVICES	MEDICARE BENEFITS		YOUR MEDICARE SUPPLEMENT COVERAGE	
	In 1989 Medicare Pays Per Benefit Period	Effective January 1, 1990, Medicare Will Pay	In 1989 Your Coverage Pays	Effective January 1, 1990, Your Coverage Will Pay Per Calendar Year
	9th through 150th day - 100% of costs period Beyond 150 days - nothing	Beyond 100 days - nothing/benefit		
MEDICARE PART B SERVICES AND SUPPLIES	80% of allowable charges (after $75 deductible calendar year)	80% of allowable charges (after $75 deductible		
PRESCRIPTION DRUGS	Inpatient presecription drugs. 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant (after $75 deductible/ calendar year)	Inpatient presecription drugs. 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant (after $75 deductible/ calendar year)		
BLOOD	80% of all costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period (after $75 deductible/calendar year)	80% of costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period (after $75 deductible/calendar year)		

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

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

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

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

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

Ins 3.39 Appendix 5

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

(Insurance company's name and address)

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

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

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

STATEMENT TO APPLICANT BY AGENT [BROKER OR OTHER REPRESENTATIVE]:

(Use additional sheets, as necessary.)

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

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

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

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

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

_____

Signature of Agent, Broker or Other Representative

_____

[Typed Name and Address of Agent or Broker]

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

_____

(Date)

_____

(Applicant's Signature)

Ins 3.39 Appendix 6

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

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

(Insurance company's name and address)

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

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

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

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

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

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

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

   If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [Company Name and Address] within 30 days if any requested information is not correct and complete, or if any requested past medical history has been left out of the application.

_____

(Company Name Agent)

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 be establishing an order in which Plans pay their claims and by providing the authority for the orderly transfer of information needed to pay claims promptly. It avoids duplication of benefits by permitting a reduction of the benefits of a Plan when, by the rules established by this section, a Plan does not have to pay its benefits first.

(c) Coordinating health benefits has been found to be an effective tool in containing health care costs. However, minimum standards of protection and uniformity are needed to protect the insured's and the public's interest.

(2) SCOPE. This section applies to all group and blanket disability insurance policies subject to s. 631.01 (1), Stats., that provide 24-hour continuous coverage for medical or dental care, treatment or expenses due to either injury or sickness that contain a coordination of benefits provision, an "excess," "anti-duplication," "non-profit" or "other insurance" exclusion by whatever name designated under which benefits are reduced because of other insurance, other than an exclusion for expenses covered by worker's compensation, employer's liability insurance, or individual traditional automobile "fault" contracts. Except as permitted under s. 632.32 (4) (b), Stats., this section applies to the medical benefits provisions in an automobile "no fault" type or group or group-type "fault" policy. A policy subject to this section may reduce benefits because of Medicare only to the extent permitted by federal law and shall comply with s. 632.755, Stats., when reducing benefits because of coverage by or eligibility for medical assistance.

(3) DEFINITIONS. In this section:

(a) "Allowable expense" means the necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made, except as provided in sub. (4).

(b) "Claim" means a request that benefits of a Plan be provided or paid. The benefits claimed may be in the form of any of the following:

1. Services, including supplies.

2. Payment for all or a portion of the expenses incurred.

3. A combination of subds. 1 and 2.

4. Indemnification.

(c) "Claim determination period" means the period of time over which allowable expenses are compared with total benefits payable in the absence of COB to determine whether overinsurance exists and how much