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. 632.895 (4) (c), 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; correction in (1) (f) made under s. 13.93 (2m) (b) 7, Stats., Register, June, 1994, No. 462.

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. 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, delivered or issued for delivery in Wisconsin 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 in Wisconsin predominantly to individuals or groups of individuals who are 65 years of age or older 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.

5. Any individual or group policy or certificate sold in Wisconsin to persons under 65 years of age and eligible for medicare by reason of disability which offers hospital, medical, surgical or other disability coverage, except for a policy or certificate which offers solely nursing home, hospital confinement indemnity or specified disease coverage.

(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;

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, the person who seeks to contract for insurance benefits.

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

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

(aj) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(al) "Health Care Expense" means expenses of health maintenance organizations associated with the delivery of health care services which expenses are analogous to incurresd losses of issuers. Such expenses shall not include:

1. Home office and overhead costs;

2. Advertising costs;

3. Commissions and other acquisition costs;

4. Taxes;

5. Capital costs;

6. Administrative costs; and

7. Claims processing costs.

(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.

(bm) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

(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 constituted 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).

(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).

(ij) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

(ik) "Replacement" means any transaction wherein new Medicare supplement insurance is to be purchased, and it is known to the agent or company at the time of application that, as part of the transaction, existing accident and sickness insurance has been or is to be lapsed, cancelled or terminated or the benefits thereof substantially reduced.

(im) 1. "Sickness" shall not be defined to be more restrictive than illness 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 illness or disease for which benefits are provided under any worker's 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), (7) and (30), no disability insurance policy or certificate shall relate its coverage to Medicare or be structured, advertised, or marketed as a Medicare supplement or as a Medicare replacement policy unless:

(a) The policy or certificate:

1. Provides only the coverage set out in sub. (5), (7) or (30) and applicable statutes and contains no exclusions or limitations other than those permitted by sub. (8). After being notified by the commissioner in writing that the federal department of health and human services has approved the Wisconsin Medicare supplement regulatory program including the Medicare Select program in sub. (30), no issuer may issue an HMO Medicare supplement policy under sub. (5) and all HMO Medicare supplement policies must be written in accordance with sub. (30).

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," "convalescent nursing home," 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 only 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 issuer if the issuer 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 (the renewal period cannot be less than the greater of 3 months, the period for which the insured has paid the premium or the period specified in the policy);

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), (7) or (30);

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 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 issuer shall issue a pro rata refund to the insured or the insured's estate.

16. Except for permitted preexisting condition clauses as described in subd. 12, no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

17. No Medicare supplement policy or certificate in force in this state shall contain benefits which duplicate benefits provided by Medicare.

18. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period not to exceed 24 months in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to the assistance. Upon receipt of timely notice, the issuer shall return to the policyholder or certificateholder that portion of the premium attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.

18m. If the suspension occurs and if the policyholder or certificateholder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted (effective as of the date of termination of the entitlement) as of the termination of the entitlement if the

policyholder or certificateholder provides notice of loss of the entitlement within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of the entitlement.

18r. Reinstitution of such coverages:

a. Shall not provide for any waiting period with respect to treatment of preexisting conditions;

b. Shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension; and

c. Shall provide for classification of premiums on terms 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 not been suspended.

(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 issuer 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), (7) or (30);

5. Is substantially in the format prescribed in Appendix 1 to this section for the appropriate category and printed in no less than 12-point type;

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) (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) (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 earned which will be returned to insureds in the form of aggregate benefits, not including anticipated refunds or credits, provided under the policy form or certificate form:

1. Is computed on the basis of anticipated incurred claims or incurred health care expenses where coverage is provided by a health maintenance organizations on a service rather than reimbursement basis and earned premiums for the entire period for which the policy form provides coverage, in accordance with accepted actuarial principles and practices;

2. Is submitted to the commissioner along with the policy form and is accompanied by rates and an actuarial demonstration that expected claims in relationship to premiums comply with the loss ratio standards in sub. (16) (d). The policy form will not be approved unless the anticipated loss ratio along with the rates and actuarial demonstration show compliance.

(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. (16) (d).

(h) All Medicare supplement policies written prior to January 1, 1992, shall comply with the standards then in effect and shall comply with sub. (14) (c).

(4m) OPEN ENROLLMENT. (a) Unless the coverage is subject to sub. (7), an issuer may not deny or condition the issuance or effectiveness of, or discriminate in the pricing of, basic Medicare supplement coverage, Medicare Select policies permitted under sub (30) or riders permitted under sub. (5) (i) for which an application is submitted during the 6-month period beginning with the first month in which an individual first enrolled for benefits under Medicare Part B or the month in which an individual turns age 65 for any individual who was first enrolled in Medicare Part B when under the age of 65 and enrolled in the Health Insurance Risk Sharing Plan under s. 619.11, Stats. on any of the following grounds:

1. Health status.

2. Claims experience.

3. Receipt of health care.

4. Medical condition.

(b) This section shall not prevent the application of any preexisting condition limitation which is in compliance with sub. (4) (a) 2.

(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. Payment of the usual and customary home care expenses 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 and kidney disease treatment as required under s. 632.895 (3) and (4), 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. Issuers 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. Issuers are not required to duplicate expenses paid by Medicare.

14. 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.

15. Coverage for at least 80% of the charges for outpatient prescription drugs after a drug deductible of no more than $6,250 per calender year.

(i) Permissible additional coverage only added to the policy as separate riders. The issuer shall issue a separate rider for each coverage the issuer chooses to offer and each rider shall be priced separately, available for purchase separately at any time, subject to underwriting and the preexisting limitation allowed in sub. (4) (a) 2., and may consist only of the following:

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 issuer 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 the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during at least the first 60 consecutive days of each trip outside the United States and a lifetime maximum benefit of at least $50,000. For purposes of this benefit, "emergency hospital, physicians and medical care" shall mean care needed immediately because of an injury or an

illness of sudden and unexpected onset. The rider shall be designated as: FOREIGN TRAVEL RIDER.

7. At least 50% of the charges for outpatient prescription drugs after a deductible of no greater than $250 per year to a maximum of at least $3,000 in benefits received by the insured per year. The rider shall be designated as: OUTPATIENT PRESCRIPTION DRUG RIDER.

(j) For HMO Medicare Select policies, only the benefits specified in sub. (30) (p) and (q), in addition to Medicare benefits.

(6) USUAL, CUSTOMARY AND REASONABLE CHARGES. An issurer can only include a policy provision limiting benefits to the usual, customary and reasonable charge as determined by the issuer for coverages described in subs. (5) (c) 5, 8 and 13 and (7) (b) 3 e, h and i. If the issuer includes such a provision, the issuer 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 the 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 issuer, 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. Payment of the usual and customary home care expenses 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;

f. Nursing home confinement and kidney disease treatment expense coverage as required under s. 632.895 (3) and (4), 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. Issuers 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. Issuers are not required to duplicate payments made by Medicare;

j. Coverage for at least 80% of the charges for outpatient prescription drugs after a drug deductible of no more than $6,250 per calendar year.

(c) Each issuer which markets a Medicare replacement policy shall have an approved Medicare supplement insurance policy or Medicare Select policy available for all currently enrolled participants at the time as the contract between the Health Care Financing Administration and the issuer is terminated.

(d) 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 issuer before disenrolling.

(e) Each issuer shall offer the rider as described in sub. (5) (i) 2. and may offer the other riders described in sub. (5) (i) and other coverages as authorized by the health care financing administration.

(8) PERMISSIBLE MEDICARE SUPPLEMENT AND MEDICARE REPLACEMENT POLICY OR CERTIFICATE EXCLUSIONS AND LIMITATIONS. (a) The coverage set out in subs. (5), (7) and (30):

1. Shall 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 issuer may exclude from coverage the expenses which Medicare Part B would have covered if the insured were enrolled in Medicare Part B. An issuer may not exclude Medicare Part B eligible expenses incurred beyond what Medicare Part B would cover.

(c) The coverages set out in subs. (5), (7) and (30) 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 hospital. For more information, see 'Health Insurance Advice for Senior Citizens', given to you when you applied for this policy."

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

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

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

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

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

(10) CONVERSION OR CONTINUATION OF COVERAGE. (a) Conversion requirements. An insured under individual, family, or group hospital or medical coverage who will become eligible for Medicare and is offered a conversion policy which is not subject to subs. (4) and (5) or (7) shall be furnished by the issuer, 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 issuer, 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 issuer 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) (b) 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" in a type size no smaller than 12 point type at the time the prospect is contacted by an intermediary or issuer 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 issuer. This pamphlet provides information on Medicare and advice to senior citizens on the purchase of Medicare supplement insurance and other health insurance. Issuers 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 issuer shall be responsible for providing applicants the revised pamphlet until 30 days after the issuer 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 issuer 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 issuer agrees to aggregate experience for the various forms in calculating rates and loss ratios.

(b) An issuer 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.

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(c) An issuer shall comply with section 1882 (c) (3) of the Social Security Act, as enacted by section 4081 (b) (2) (C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203, by:

1. Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

2. Notifying the participating physician or supplier and the beneficiary of the payment determination;

3. Paying the participating physician or supplier directly;

4. Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;

5. Paying user fees for claim notices that are transmitted electronically or otherwise;

6. Providing to the U.S. secretary of health and human services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers; and

7. Certifying compliance with the requirements set forth in this subsection on the Medicare supplement insurance experience reporting form.

(d) Except as provided in sub. (1), an issuer shall continue to make available for purchase any policy form or certificate form issued after August 1, 1992 that has been approved by the commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.

1. An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner, the issuer shall no longer offer for sale the policy form or certificate form in this state.

2. An issuer that discontinues the availability of a policy form or certificate form pursuant to subd. 1., shall not file for approval a new policy form or certificate form of the same type as the discontinued form for a period of 5 years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

3. This subsection shall not apply to the riders permitted in subs. (5) (j).

(e) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

(f) A change in the rating structure or methodology shall be considered a discontinuance under par. (d) 1. unless the issuer complies with the following requirements:

1. The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and resultant rates.

2. The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential which is in the public interest.

(g) Except as provided in par. (h) the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in sub. (31).

(h) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

(i) No issuer may issue a Medicare supplement policy or a certificate to an applicant 75 years of age or older, unless the applicant is subject to sub. (4m) or, prior to issuing coverage, the issuer either agrees not to rescind or void the policy except for intentional fraud in the application, or obtains one of the following:

1. A copy of a physical examination.

2. An assessment of functional capacity.

3. An attending physician's statement.

4. Copies of medical records.

(j) Notwithstanding sub. (a), an issuer may file and use only one individual Medicare Select policy form and one group Medicare Select policy form. These policy forms shall not be aggregated with non-Medicare Select forms in calculating premium rates, loss ratios and premium refunds.

(k) If an issuer nonrenews an insured who has a nonguaranteed renewable Medicare supplement policy with the issuer, the issuer shall at the time any notice of nonrenewal is sent to the insured, offer a currently available individual replacement Medicare supplement policy and those currently available riders resulting in coverage substantially similar to coverage provided by the replaced policy without underwriting. This replacement shall comply with sub. (27).

(l) For policies issued between December 31, 1980, and January 1, 1992, issuers shall combine the Wisconsin experience of all policy forms of the same type (individual or group) for the purposes of calculating the loss ratio under sub. (16) (c) and rates. The rates for all such policies of the same type shall be adjusted by the same percentage. Issuers may combine the Wisconsin experience of all policies issued prior to January 1, 1981, with those issued between December 31, 1980, and January 1, 1992, if the issuer uses the 60% loss ratio for individual policies and the

70% loss ratio for group policies. If the Wisconsin experience is not credible, then national experience can be considered.

(m) If Medicare determines the eligibility of a covered service, then the issuer must use Medicare's determination in processing claims.

(15) FILING REQUIREMENTS FOR ADVERTISING. Prior to use in this state, every issuer 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 issuer or Medicare supplement policy, each agent utilizing the advertisement shall file the advertisement with the commissioner prior to using it. Issuers 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 AND RATES FOR EXISTING POLICIES. (a) Every issuer providing Medicare supplement coverage on a group or individual basis on policies or certificates issued before or after August 1, 1992 in this state shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis to earned premiums by policy duration for approval by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of par. (d) when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

(b) The supporting documentation shall also demonstrate in accordance with the actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. Such demonstration shall exclude active life reserves. 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 enhancements in Medicare benefits, every issuer providing Medicare supplement policies or certificates in this state shall file with the commissioner in accordance with the applicable filing procedures of this state appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the current premium for the applicable policies or certificates. Supporting documents as necessary to justify the adjustment shall accompany the filing.

1. Every issuer shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or certificate 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 issuer for such Medicare supplement insurance policies or certificates. 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.

2. If an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this subsection.

3. An issuer shall file any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. Such riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided provided by the policy or certificate.

(d) For purposes of sub. (4) (e) and this subsection, 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, and

3. For existing policies subject to this subsection, the loss ratio shall be calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices.

(e) An issuer may not use or change any premium rates for an individual or group Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner and in accordance with sub. (4) (g).

(21) COMMISSION LIMITATIONS. (a) An issuer 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 issuer 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 and certificates 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 and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

(b) Except for riders or endorsements by which the issuer 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 or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall 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.

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

(e) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy and 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, an issuer shall notify its policyholders, contractholders and certificateholders of modifications it has made to Medicare supplement insurance policies or certificates 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 policy or certificate, and

2. Inform each policyholder or certificateholder 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 statements and questions:

[Statements]

1. You do not need more than one Medicare supplement policy.

2. If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

3. The benefits and premiums under your Medicare supplement policy will be suspended during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstituted if requested within 90 days of losing Medicaid eligibility.

4. Counseling services are available to provide advice concerning your purchase of Medicare supplement insurance and concerning Medicaid. See the booklet "Health Insurance Advice for Senior Citizens" which you received at the time you were solicited to purchase this policy.

[Questions]

To the best of your knowledge:

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

If so, with which company?

6. Do you have any other health insurance policies that provide benefits which this Medicare supplement policy would duplicate?

a. If so, with which company?

b. What kind of policy?

7. If the answer to question 5 or 6 is yes, do you intend to replace these medical or health policies with this policy [certificate]?

8. Are you covered by Medicaid?

(b) Agents shall list, in a supplementary form signed by the agent and submitted to the issuer 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.

(bl) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the issuer, shall be returned to the applicant by the issuer upon delivery of the policy.

(c) Upon determining that a sale will involve replacement, an issuer, other than a direct response issuer, 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 in no less than 10 point type. 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 issuer. A direct response issuer 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 issuer shall be provided in substantially the form as shown in Appendix 5.

(e) If the application contains questions regarding health, include a statement that health questions should not be answered if the applicant is in the open-enrollment period described in sub. (4m).

(24) STANDARDS FOR MARKETING. (a) Every issuer 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 issuer 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 issuers 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 issuer.

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 issuer.

(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 issuer shall mail the entire premium refund directly to the person who paid the premium.

(g) The terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall not be used unless the policy is issued in compliance with this section.

(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 issuer within 7 calendar days after taking the application. An agent shall mail the portion of any premium collected due the issuer to the issuer within 7 days after receiving the premium.

(26) REPORTING OF MULTIPLE POLICIES. (a) On or before March 1 of each year, every issuer 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 and listed on a form in substantially the same format as Appendix 7 on or before March 1 of each year.

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

(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 issuer 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 issuer 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 issuer 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) FILING AND APPROVAL REQUIREMENTS. An issuer shall not deliver or issuer for delivery a policy or certificate to a resident of this state unless the policy form or certificate has been filed with and approved by the commissioner in accordance with filing requirements and procedures prescribed by the commissioner.

(30) MEDICARE SELECT POLICIES AND CERTIFICATES. (a) 1. This subsection shall apply to Medicare Select policies and certificates.

2. No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

(b) For the purposes of this section:

1. "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

2. "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices or provision of services concerning a Medicare Select issuer or its network providers.

3. "Medicare Select issuer" means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

4. "Medicare Select policy" or "Medicare Select certificate" mean, respectively, a Medicare supplement policy or certificate that contains restricted network provisions.

5. "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

6. "Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

7. "Service area" means the geographic area approved by the commissioner within which an issuer is authorized to offer a Medicare Select policy.

(c) The commissioner may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this subsection and section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, if the commissioner finds that the issuer has satisfied all of the requirements of this subsection.

(d) A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the commissioner.

(e) A Medicare Select issuer shall file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

1. Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

a. Such services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual medical travel times within the community.

b. The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either to deliver adequately all services that are subject to a restricted network provision or to make appropriate referrals.

c. There are written agreements with network providers describing specific responsibilities.

d. Emergency care is available 24 hours per day and 7 days per week.

e. In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting such providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

2. A statement or map providing a clear description of the service area.

3. A description of the grievance procedure to be utilized.

4. A description of the quality assurance program, including:

a. The formal organizational structure;

b. The written criteria for selection, retention and removal of network providers; and

c. The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

5. A list and description, by specialty, of the network providers.

6. Copies of the written information proposed to be used by the issuer to comply with par. (i).

7. Any other information requested by the commissioner.

(f) 1. A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing such changes. Such changes shall be considered approved by the commissioner after 30 days unless specifically disapproved.

2. An updated list of network providers shall be filed with the commissioner at least quarterly.

(g) A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if:

1. The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and

2. It is not reasonable to obtain such services through a network provider.

(h) A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

(i) A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

1. An outline of coverage in substantially the same format as Appendix 1 sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

a. Other Medicare supplement policies or certificates offered by the issuer; and

b. Other Medicare Select policies or certificates.

2. A description, including address, phone number and hours of operation, of the network providers, including primary care physicians, specialty physicians, hospitals and other providers.

3. A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized.

4. A description of coverage for emergency and urgently needed care and other out of service area coverage.

5. A description of limitations on referrals to restricted network providers and to other providers.

6. A description of the policyholder's or certificateholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.

7. A description of the Medicare Select issuer's quality assurance program and grievance procedure.

8. A designation: MEDICARE SELECT POLICY. This designation shall be immediately below and in the same type size as the designation required in sub. (5) (a) or (7) (b) 1.

9. The caption, except that the word "certificate" may be used instead of "policy," if appropriate: "The Wisconsin Insurance Commissioner has set standards for Medicare Select policies. 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."

(j) Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to par. (i) of this section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

(k) A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from its subscribers. Such procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

1. The grievance procedure shall be described in the policy and certificate and in the outline of coverage.

2. At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

3. Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

4. If a grievance is found to be valid, corrective action shall be taken promptly.

5. All concerned parties shall be notified about the results of a grievance.

6. The issuer shall report no later than each March 31st to the commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

(l) At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

(m) 1. At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for 6 months.

2. For the purposes of subd. 1., a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

(n) Medicare Select policies and certificates shall provide for continuation of coverage in the event the U.S. secretary of health and human services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure

of the Medicare Select program to be reauthorized under law or its substantial amendment.

1. Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issurer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies and certificates available without requiring evidence of insurability.

2. For the purposes of subd. 1., a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

(o) A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States department of health and human services, for the purpose of evaluating the Medicare Select Program.

(p) A Medicare Select policy shall contain the following benefits:

1. The "basic Medicare supplement coverage" as described in sub. (5) (c).

2. Coverage for the Medicare Part A hospital deductible as described in sub. (5) (i) 1.

3. Coverage for home health care for an aggregate of 365 visits per policy year as described in sub. (5) (i) 2.

4. Coverage for the Medicare Part B medical deductible as described in sub. (5) (i) 3.

5. Coverage for the difference between Medicare Part B eligible charges and the actual charges for authorized referral services. This coverage shall not be described with words or terms that would lead insureds to believe the coverage is for Medicare part B Excess Charges as described in sub. (5) (i) 4.

6. Coverage for benefits obtained outside of the United States as described in sub. (5) (i) 5.

7. Coverage for preventive health care services as described in sub. (5) (c) 14.

8. Coverage for at least 80% of the charges for outpatient prescription drugs after a drug deductible of no more than $6,250 per calendar year.

(q) A Medicare Select policy may include permissible additional coverage as described in sub. (5) (i) 7. This rider, if offered, shall be added to the policy as a separate rider or amendment, shall be priced separately and available for purchase separately.

(31) REFUND OR CREDIT CALCULATION. (a) An issuer shall collect and file with the commissioner by May 31 of each year the data contained in the reporting form contained in Appendix 6 for each type of policy form as described in sub. (14).

(b) If, on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type of policy form as described in sub. (14). For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

(c) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds $5.00. Such refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary of health and human services, but in no event shall it be less than the average rate of interest for 13-week U.S. treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

(32) PUBLIC HEARINGS. The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of this section if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for such reporting period. Public notice of such hearing shall be furnished in a manner deemed appropriate by the commissioner.

(33) ADDITIONAL BENEFITS FOR POLICIES RENEWED. On the renewal of any Medicare supplement policy the benefits required in subs. (5) (c) 8 and 13 and (7) (b) 3. h and i shall be provided.

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: The rule revisions published in June, 1994 first apply to any policy issued, renewed or solicited on or after September 1, 1994.

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; emerg. r. (3) (ai), (bl), (gl), (gm) and (il), (4) (f), (17) to (20), (24) (d), renum. (5) (i) 6 to (5) (c) 14, am. (1) (a), (3) (ag), (ah), (im), (4) (intro.), (a) 1., 3., 5., 10., 14., and 18.b., (b) 4., 5. and 7. and (c) 3., (e), (g) 2., (4m), (5) (i) (intro.), 5. and 7., (8) (a) (intro.), (a) 1. and (c), (11), (16), (22) (a) to (f), (23) (a), (c) and(d), (26) (b), (27), appendix 1 and 5, r. and recr. (14) (c), (29), appendix 6, cr. (2) (a) 5., (3) (aj), (al), (bm), (ij) and (ik), (4) (a) 16. to 18., (h), (5) (j), (14) (d) to (j), (23) (bl), (24) (g), (30), (33), appendix 7, eff. 1-1-92; am. (1) (a), (2) (intro.), (a) 3., (3) (ag), (ah), (im), (4) (intro.),(a) 1., 3., 5., 10., and 14., (b) 4., 5., and 7., (c), 3., (e), (g) 2., (4m), (5) (i) (intro.), 5. and 7., (6) (intro.), (8) (a) (intro.), (a) 1. and (c), (11), (16), (22), (a), (b), (d) to (f), (23) (a), (c) and (d), (26) (b), (27), appendix 1,4 and 5, r. (3) (ai), (bl), (gl), (gm), and (il), (4) (f), (17) to (20) and (22) (c), (24) (d), cr. (2) (a) 5., (3) (aj), (al), (bm), (ij) and (ik), (4) (a) 16. to 18r. (h), (14) (d) to (j), (23) (bl), (24) (g), (30) to (33), and appendix 7, renum. (5) (i) 6. to be (5) (c) 14., r. and recr. (14) (c) and (29), (7) (d) renum. from Ins 3.13 (2) (jm), Register, July, 1992, No. 439, eff. 8-1-92; r. (2) (d) 2., am. (3) (al) (intro.), (4) (a) 1., 5., 7., 15., 16. and 18., (4) (b) 1., (4m) (a) (intro.), (5) (c) 5., 6., 8. and 13., (5) (i) (intro.), 5., (6) (intro.), (7) (a), (7) (b) 3. e., f., h. and l., (7) (c), (7) (d) 2., (8) (b) (10) (a) (intro.), (b) (intro.), (c) (intro.) and (d) 1., (11), (14) (a), (b), (i) and (j), (15), (16) (c) (intro.) and 1., (21) (a) and (c), (22) (b), (23) (b) to (d), (24) (a) (intro.), (b), (c) 1. and 3., (f), (25) (c), (26) (a) (intro.), (27), (28) (a) (intro.), (b) (intro.) and (c), (30) (c), (i) 1. intro., and (p) 7., appendix 1 and 6, cr. (5) (c) 15., (7) (b) 3. j., (7) (e), (14) (k) to (m), (23) (e), (30) (i) 9 and (30) (p) 8., Register, June, 1994, No. 462, eff. 9-1-94; correction in (20) (d) made under s. 13.93 (2m) (b) 7, Stats., Register, June, 1994, No. 462.

Ins 3.39 Appendix 1

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

PREMIUM INFORMATION

(1) We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this state. [If the premium is based on the increasing age of the insured, include information specifiying when premiums will change.]

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to (insert issuer's address). If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all your payments directly to you.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs.

(2) 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

(Issuers 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 ☐ 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 ☐ 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, in-patient and out-patient medical services and supplies at a hospital, physical and speech therapy, ambulance, and outpatient psychiatric care	Initial ($) deductible	$0	Nothing or ☐ OPTIONAL PART B DEDUCTIBLE RIDER*	
	After initial deductible	80% of Medicare eligible charge	20% of Medicare eligible charge and ☐ OPTIONAL MEDICARE PART B EXCESS CHARGES RIDER*	
Outpatient prescription drugs	Initial $6,250 deductible	$0	80% of charges over $6,250 and ☐ OPTIONAL OUTPATIENT PRESCRIPTION DRUG RIDER*	
Blood		80% of costs except nonreplacement fees (blood deductible) for first 3 pints (after $ ___ deductible/ calendar year)	20% of all eligible costs and the first 3 pints in each calendar year	
Immuno-suppressive 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 immuno-suppressive 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:

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult 'The Medicare Handbook' for more details.

(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 COVERAGE

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 the Medicare eligible charge 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. Outpatient prescription drug charges
At least 50% of the charges after a deductible of $ ____ (no more than $250) to a maximum benefit of $3,000 per year.

$( ) 6. Foreign travel rider
After a deductable not greater than $250, covers at least 80% of expenses associated with emergency medical care received outside the U.S.A. during the first 60 days of a trip with a maximum of at least $50,000

$( ) 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.

(Note: Medicare Select policies shall modify the outline to reflect the benefits which are contained in the policy and the optional rider.)

(12) If premiums for each rating classification are not listed in the outline of coverage under subsection (11), then the issuer 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 officer 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 — 19--

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 19-- Medicare Pays Per Benefit Period	Effective January 1, 19--, Medicare Will Pay	In 19-- Your Coverage Pays	Effective January 1, 19--, Your Coverage Will Pay Per Calendar Year
MEDICARE PART A SERVICES AND SUPPLIES				
In patient Hospital Services	Unlimited number of hospital days after $-- deductible	All but $-- for the first 60 days/benefit period		
Semi-Private Room & Board		All but $-- a day for 61st-90th days/benefit period		
Misc. Hospital Services & Supplies, such as Drugs, X-Rays, Lab Tests & Operating Room		All but $-- 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		

SERVICES	MEDICARE BENEFITS		YOUR MEDICARE SUPPLEMENT COVERAGE	
	In 19-- Medicare Pays Per Benefit Period	Effective January 1, 19--, Medicare Will Pay	In 19-- Your Coverage Pays	Effective January 1, 19--, Your Coverage Will Pay Per Calendar Year
SKILLED NURSING FACILITY CARE	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	First 20 days 100% of costs		
	Additional 80 days all but $ (current amount per day)	Additional 80 days all but $ (current amount per day)		
MEDICARE PART B SERVICES AND SUPPLIES	80% of allowable charges (after $-- deductible calendar year)	80% of allowable charges (after $-- deductible		
PRESCRIPTION DRUGS	Outpatient presecription drugs. 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant (after $-- deductible/ calendar year)	Outpatient presecription drugs. 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant (after $-- deductible/ calendar year)		
BLOOD	80% of all costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period (after $--deductible/calendar year)	80% of costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period (after $-- deductible/calendar year)		

[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 terminate existing medicare supplement insurance or other health insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy only if, after due consideration, you find that the purchase of this medicare supplement coverage is a wise decision. Do not cancel your current policy until you have received your new policy and are sure you want to keep it.

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

I have reviewed your current medical or health insurance coverage. The replacement of insurance involved in this transaction does not duplicate coverage, to the best of my knowledge. The replacement policy is being purchased for the following reason(s):

_____ Additional benefits.

_____ No change in benefits and lower premiums.

_____ Fewer benefits and lower premiums.

_____ Other.

(please specify)_____

_____

_____

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 Medicare supplement policy.

3. If, 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, review it carefully to be certain that all requested information has been properly reported. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure you want to keep it.

_____

Signature of Agent, Broker or Other Representative*

[Typed Name and Address of Issuer, Agent or Broker]

_____

(Applicant's Signature)

_____

(Date)

* Signature not required for direct response sales.

(Note: Paragraphs 1 and 2 of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexising condition limitiation.)

Ins 3.39 Appendix 6

MEDICARE SUPPLEMENT REFUND CALCULATION FORM FOR CALENDAR YEAR _____

TYPE _____ SMSBP (w) [form number] _____
for the State of _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Person Completing This Exhibit _____
Title _____ Telephone Number _____

Line	(a) Earned Premium (x)	(b) Incurred Claims (y)
1. Current Year's Experience		
a. Total (all policy years)		
b. Current year's issues (z)		
c. Net (for reporting purposes = 1a-1b	_____	_____
2. Past Years' Experience (All policy Years)	_____	_____
3. Total Experience (net current Year + Past Years' Experience)	_____	_____
4. Refunds last year (Excluding Interest)	_____	
5. Previous refunds since Inception (Excluding interest) (add lines 4 and 5)	_____	
6. Refunds Since Inception (Excluding Interest) (add lines 4 and 5)	_____	
7. Benchmark Ratio Since Inception (SEE WORKSHEET FOR RATIO 1)	_____	
Experience Ratio Since Inception		

Ratio 2 = $\frac{\text{Total Actual Incurred Claims (line 3, col b)}}{\text{Total. Earned Prem. (line 3, col a) - Refunds Since Inception (line 6)}}$

9. Life Years Exposed since Inception _____

If the Experience Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.

10. Tolerance permitted (obtained from creditability table) _____

11. Adjustment to Incurred Claim for Creditability
Ratio 3 = Ratio 2 + Tolerance

If Ratio 3 is more than Benchmark Ratio (ratio 1) a refund or credit to premium is not required.

If Ratio 3 is less than the Benchmark Ratio, then proceed.

12. Adjusted Incurred Claims =

[Tot. Earned Premiums (line 3, col a) - Refunds Since Inception (line 6)] x Ratio 3 (line 11)

13. Refund = Total Earned Premiums (line 3, col a) - Refunds Since Inception (line 6) - $\frac{\text{Adjusted Incurred Claims (line 12)}}{\text{Benchmark Ratio (Ratio 1)}}$

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund and/or credit against premiums to be used must be attached to this form.

Medicare Supplement Creditability Table

Life Years Exposed Since Inception	Tolerance
10,000 +	0.0%
5,000 — 9,999	5.0
2,500 — 4,999	7.5
1,000 — 2,499	10.0
500 — 999	15.0

If less than 500, no creditability.

(w) "SMSBP" = Standardized Medicare Supplement Benefit Plan
For Wisconsin reports, show the applicable policy form number.

(x) Includes modal loadings and fees charged

(y) Excludes Active Life Reserves

(z) This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Name - Please Type

_____
Title

_____
Date

Worksheet

REPORTING FORM FOR THE CALCULATION OF BENCHMARK
RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES
FOR CALENDAR YEAR _____

TYPE _____ SMSBP (p) _____
for the State of _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____
Person Completing This Exhibit _____
Title _____ Telephone Number _____

(a) Year	(a) Earned Premium	(c) Factor	(d) (b) x (c)	(e) Cumulative Loss Ratio	(f) (d) x (e)	(g) Factor	(h) (b) x (g)	(i) Cumulative Loss Reserve	(j) (h) x (i)	(o) Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.4
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15		4.175		0.493		8.684		0.725		0.77
Total:		(k):		(l):		(m):		(n):		

Benchmark Ratio Since Inception: (l + n) / (k + m):

(a): Year 1 is the current calendar year - 1
Year 2 is the current calendar year - 2
(etc.)
(Example: If the current year is 1991, then:
Year 1 is 1990; Year 2 is 1989; etc.)

(b): For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year

(o): These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for information purposes only.

(p): "SMSBP" = Standardized Medicare Supplement Benefit Plan. For Wisconsin reports, show the applicable policy form number.

701R51
05/14/92

Worksheet

REPORTING FORM FOR THE CALCULATION OF BENCHMARK
RATIO SINCE INCEPTION FOR GROUP POLICIES
FOR CALENDAR YEAR _____

TYPE _____ SMSBP (p) _____
for the State of _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____
Person Completing This Exhibit _____
Title _____ Telephone Number _____

(a) Year	(a) Earned Premium	(c) Factor	(d) (b) x (c)	(e) Cumulative Loss Ratio	(f) (d) x (e)	(g) Factor	(h) (b) x (g)	(i) Cumulative Loss Reserve	(j) (h) x (i)	(o) Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.8
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15		4.175		0.567		8.684		0.838		0.89
Total:		(k):		(l):		(m):		(n):		

Benchmark Ratio Since Inception: (l + n) / (k + m):

(a): Year 1 is the current calendar year - 1
Year 2 is the current calendar year - 2
(etc.)
(Example: If the current year is 1991, then:
Year 1 is 1990; Year 2 is 1989; etc.)

(b): For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year

(o): These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for information purposes only.

(p): "SMSBP" = Standardized Medicare Supplement Benefit Plan. For Wisconsin reports, show the applicable policy form number.

701RS2
05/14/92

Ins 3.39 Appendix 7

FORM FOR REPORTING
MEDICARE SUPPLEMENT POLICIES

Company Name: _____

Address: _____

_____

Phone Number: _____

Due March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate Number	Date of Issuance

_____
Signature

_____
Name and Title (please type)

_____
Date

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

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