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.

(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 i., (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.