STATE OF WISCONSIN

# Fact Sheet on Mandated Benefits in Health Insurance Policies

OFFICE OF THE COMMISSIONER OF INSURANCE PI-019 (R 04/2011)

Health insurance policies sold in Wisconsin often include "mandated benefits." These are benefits that an insurer must include in certain types of health insurance policies. Some mandated benefits apply only to group policies. Some apply both to policies sold to individuals and to groups. Most apply only to policies issued or renewed after a certain date.Except for health maintenance organizations (HMOs) organized as cooperatives under ch. 185, Wis. Stat., HMOs are required to provide the same benefits as traditional insurers. Cooperative HMOs are subject to the mandates regarding chiropractors, optometrists, genetic testing, nurse practitioners, newborns, adopted children, HIV drugs, dentists, temporomandibular (TMJ) disorders, breast reconstruction, and hospital and ambulatory surgery center charges, anesthetics for dental care, coverage of certain health care costs in cancer clinical trials, and coverage of student on medical leave.

This brochure gives a brief description of current mandated benefits.

**Professional Health Care Services**

- **Nonphysician Providers** - *Unless the policy provides otherwise,* insurers may not refuse to pay for services by certain nonphysician providers if the service is covered by the policy and the professional is licensed to provide the service.

  Insurers *may* refuse to pay for services given by certain providers if the policy clearly states that this is the case. For example, insurers could refuse to pay for services provided by a social worker in private practice *even though a social worker is licensed to provide services covered under the contract*.

  This applies both to group and to individual policies. [s. 632.87(1), Wis. Stat.]

- **Optometrists** - Insurers may not exclude coverage for services provided by an optometrist if the contract covers the same service when it is provided by another health care provider. Insurers may exclude all vision care services and procedures from coverage. This applies to both individual and group policies. [s. 632.87(2) and (3), Wis. Stat.]

- **Chiropractors -** All health insurance policies must cover services provided by a chiropractor if the policy would provide coverage for the same services if performed by a physician or osteopath. Policies may not require the insured to be referred to a chiropractor by a physician to receive benefits.

  Insurers may apply the same deductible and copayment provisions to chiropractic care that apply to all other benefits. In addition, insurers may apply cost containment or quality assurance measures to chiropractic care if it applies those provisions to nonchiropractic benefits. For example, an HMO can limit chiropractic care for its enrollees to those chiropractors who are either employed by or under contract to the HMO. [s. 632.87(3), Wis. Stat.]

- **Nurse Practitioners** - Health insurance policies that provide coverage for Papanicolaou (PAP) tests, pelvic examinations, and associated laboratory work if performed by a physician must also provide coverage for these services when performed by a nurse practitioner acting within the scope of his or her license.

  This applies to all insured policies, all plans offered by the Group Insurance Board, and all self-funded plans offered by school districts or municipalities. [s. 632.87(1) and (5), Wis. Stat.]

- **Dentists** - All health insurance policies are required to provide coverage for diagnosis or treatment of a condition or complaint performed by a licensed dentist if the policy covers diagnosis and treatment of the condition if performed by any other health care provider. [s. 632.87(4), Wis. Stat.]

**Adopted Children**

All health insurance policies that provide coverage for dependent children must cover adopted children and children placed for adoption on the same terms and conditions as natural children. Policies may not exclude or limit coverage of a disease or physical condition of the child because the disease or condition existed before coverage under the policy began. This applies to all policies, including plans offered by the state to its employees, cities, counties, school districts, cooperative sickness care plans, and prepaid plans. [s. 632.896, Wis. Stat.]

**Handicapped Children**

Hospital or medical expense policies that cover dependent children may end coverage when the child reaches maturity. However, coverage of a dependent child cannot end while the child continues to be *both:*

- Incapable of self-sustaining employment because of a mental retardation or physical handicap; and

- Chiefly dependent upon the person insured under the policy for support and maintenance.

This applies both to group and individual policies. Insurers can require notice of continued dependence after a child reaches the maximum age under the policy. [s. 632.88, Wis. Stat.]

**Mental Health Parity**

Wisconsin's current mandate is amended to remove the minimum coverage amounts for the treatment of mental and nervous disorders and substance use disorders. Group health benefit plans and self-insured health plans of the state or of a county, city, town, village, or school district that provides coverage for inpatient hospital treatment or outpatient treatment must provide coverage of inpatient hospital services, outpatient services, and transitional treatment arrangements for the treatment of nervous and mental disorders and substance use disorders.

Individual health plans are not required to cover mental health or substance use disorder services; however, if coverage is provided, it must be at a parity level.

Treatment limitations for mental health and substance use disorder services shall be no more restrictive than the most common or frequent type of treatment limitations applied to substantially all other coverage under the plan.

These provisions do not apply to a health care plan offered by a limited service health organization or by a preferred provider plan that is not a defined network plan or to a hospital indemnity, income continuation, accident only, long-term care, or Medicare supplement policy.

An exemption is provided for small employers who provide health coverage for their employees through a group health benefit plan if the employer has fewer than 10 eligible employees on the first day of the plan year. Employers who qualify for and elect the small employer exemption under s. 632.89 (3f), Wis. Stat., must first notify the insurer who in turn will inform the employer to notify all enrollees under the plan within 30 days that they have elected an exemption.

A cost exemption also applies for employer plans where the increase exceeds 2% in the first plan year or 1% in any plan year thereafter. Specifically, an insurer offering a group health benefit plan shall have a qualified actuary determine whether the employer is eligible for a cost exemption based on the actual group claims experience in accordance with s. 632.89 (3c), Wis. Stat. Additionally, insurers may require employers to provide at least 90 days' advance notice to the insurer from the employer's renewal date for obtaining the determination.

Despite exemptions from the state nervous and mental disorders and substance use disorders coverage requirement, state law requires compliance with the minimum mandated coverage requirements and limitations contained in s. 632.89 (2), 2007 Wis. Stat., for treatment of services for nervous and mental disorders and substance use disorders.

Coverage may be subject to any exclusions and limitations; deductibles; co-payments; coinsurance; annual and lifetime payment limitations; out-of-pocket limits; out-of-network charges; day, visit, or appointment limits; limitations regarding referrals to nonphysician providers and treatment programs; and duration or frequency of coverage limits if no more restrictive than the most common or frequent type of treatment limitations applied to substantially all other coverage under the plan. Any overall deductible amount or annual or lifetime limit or out-of-pocket limit for the plan shall include expenses incurred for the treatment of nervous and mental disorders and substance use disorders.

Health plans that provide coverage for the treatment of mental health and substance use disorders are required to make available the criteria for determining medical necessity under the plan with respect to that coverage. The criteria must be made available to any

current or potential insured, participant, beneficiary, or contracting provider. Also, health plans that provide coverage for mental health and substance use disorders and deny coverage for services for treatment shall, upon request, make the reason for the denial available to the insured, participant, or beneficiary.

Mandated coverage for mental health and substance use disorders does not apply to treatment for autism spectrum disorders.

Federal law may provide additional coverage under provisions included in the Patient Protection and Affordable Care Act (PPACA) and Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008.

The above provisions take effect for health benefit plans that are issued or renewed and governmental self-insured health plans that are established, extended, modified, or renewed on December 1, 2010. [s. 632.89, Wis. Stat.]

**Home Health Care**

Both group and individual health policies that provide benefits for inpatient hospital care must provide coverage for the usual and customary fees for at least 40 home health care visits per year. Home health care may include intermittent home nursing care, home health aide services, various types of therapy, medical supplies, medication prescribed under the home care plan, and nutrition counseling. If two or more insurers jointly provide health insurance coverage to an insured under two or more policies, home health care coverage is required under only one of the policies.

Coverage may be limited to cases where hospitalization or skilled nursing confinement would be necessary if home care were not provided and the necessary care cannot be provided by the patient's family without undue hardship. Only state-licensed or Medicare-certified home health agencies or certified rehabilitation agencies must be covered.

In addition to the 40 visits, insurers must offer buyers of Medicare supplement policies coverage for up to 365 visits a year, including those visits paid by Medicare. [s. 632.895(2), Wis. Stat.]

**Skilled Nursing Care**

Policies that cover hospital expenses must cover at least 30 days of skilled nursing care to patients who enter a licensed skilled nursing facility within 24 hours after discharge from a hospital. Coverage may be limited to care that is medically necessary as certified by the attending physician every seven days and that is for the same condition treated in the hospital. Skilled nursing care is narrowly defined. Many people in nursing homes are not receiving skilled care. [s. 632.895(3), Wis. Stat.]

**Kidney Disease**

Policies that cover hospital expenses must provide at least $30,000 of coverage per year for inpatient and outpatient treatment of kidney disease, including dialysis, transplantation, and donor-related services. The coverage is not required to duplicate Medicare benefits and may be subject to the same limitations that apply to other covered health conditions.
[s. 632.895(4), Wis. Stat.]

**Mammography**

All health insurance policies except specified disease, Medicare supplement, or long-term care policies, must provide women between the ages of 45 and 49 two examinations by low-dose mammography. Insurers may refuse to provide coverage for an examination by low-dose mammography for a woman aged 45 to 49 if she has had such an examination within the previous two years. Insurers may apply any mammogram obtained during that age period, even if obtained prior to coverage under the policy, toward the two mandated examinations. Women who are age 50 to 65 must be covered for annual mammograms.

Coverage is required regardless of whether the woman shows any symptoms. Policies may not apply exclusions or limitations that do not apply to other radiological examinations covered under the policy. The mammography examinations shall be performed at the direction of a licensed physician or nurse practitioner unless all of the following apply:

- The woman does not have an assigned or regular physician or nurse practitioner when the examination is performed.
- The woman designates a physician to receive the results.
- Any previously obtained mammography examination was obtained at the direction of a licensed physician or nurse practitioner.

[s. 632.895(8), Wis. Stat.]

**Newborn Infants**

All health insurance policies must provide coverage from the moment of birth for a newborn child of the insured. The newborn shall receive the same coverage that the policy provides for any children covered or eligible for coverage under the policy. The only exception is that waiting periods do not apply. If a

pregnant person or a person whose spouse is pregnant applies for a policy providing hospital or medical expense benefits, insurers may not issue a policy that excludes or limits benefits for the expected child. Insurers must issue the policy without exclusions or limitations or decline or postpone the application. Coverage for newborn children must include congenital defects and birth abnormalities as an injury or sickness under the policy.

If the payment of a specific premium or subscription fee is required to provide coverage for a child, policies may require that notification of a child's birth and payment of the required premiums or fees be furnished to the insurer within 60 days after the date of birth. Insurers may refuse to continue coverage beyond the 60-day period if such notification is not received, unless within one year after the birth of the child the insured makes all past due payments with interest at the rate of 5-1/2% per annum.

If the payment of a specific premium or subscription fee is not required to provide coverage for a child, the policy or contract may request notification of the birth of a child but may not deny or refuse to continue coverage if such notification is not furnished. Benefits may exclude costs associated with a normal delivery. [s. 632.895(5), Wis. Stat.]

**Coverage of Grandchildren**

Health policies that provide coverage for any child of the insured shall provide the same coverage for all children of that child until that child reaches the age of 18. [s. 632.895(5m), Wis. Stat.]

**Diabetes**

Policies that cover expenses for the treatment of diabetes shall provide coverage for insulin infusion pumps, other equipment and supplies, including insulin, and diabetic self-management education programs. Insurers may apply the same deductible and coinsurance provisions that apply to other covered expenses. Coverage may be limited to the purchase of one pump per year, and the insured may be required to use the pump 30 days before purchase.

Effective January 1, 2003, all health insurance policies issued or renewed after that date that provide coverage of expenses incurred for the treatment of diabetes shall also provide coverage for expenses incurred for prescription medication used in the treatment of diabetes. Insurers may apply the same exclusions, limitations, deductibles and coinsurance provisions that apply to other covered expenses. [s. 632.895(6), Wis. Stat.]

**Maternity Coverage**

If a group health policy provides maternity coverage for anyone covered under the policy, it must provide coverage for all persons covered under the policy. Insurers may not apply exclusions and limitations to the mandated maternity coverage that do not apply to other maternity coverage provided under the policy. [s. 632.895(7), Wis. Stat.]

**Genetic Testing**

Insurers, other than insurers writing life or income continuation coverage, are prohibited from:

- Requiring an individual or a member of the individual's family to obtain a genetic test using DNA from the person's blood to determine the presence of a genetic disease or disorder.
- Requiring an individual to reveal if he or she or a member of the family has had a genetic test and revealing the results of that test.
- Requiring or requesting a health care provider to reveal either that an individual or family member had a genetic test or the results of a genetic test.
- Conditioning coverage on whether a person or member of a person's family has had a genetic test.
- Basing premium rates or other aspects of insurance coverage on whether a person or a person's family member has had a genetic test and revealing the results of the test.

Insurers that write life or income continuation coverage who obtain genetic test information about an individual or family member are prohibited from:

- Using the information in writing any type of insurance other than life or income continuation.
- Setting rates or coverage conditions that are not reasonably related to the risk involved. [s. 631.89, Wis. Stat.]

**Drugs for Treatment of HIV Infection**

All health insurance policies that provide coverage of prescription medicine shall provide coverage for each drug that satisfies all of the following:

- Is prescribed by the insured’s physician for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection.

- Is approved by the Federal Food and Drug Administration for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection, including each investigational new drug that is approved under 21 CFR 312.34 to 312.36 for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection and that is in or has completed a phase 3 clinical investigation performed in accordance with 21 CFR 312.20 to 312.33.

- If the drug is an investigational new drug described in subd. 2, is prescribed and administered in accordance with the treatment protocol approved for the investigational new drug under 21 CFR 312.34 to 312.36.

Coverage of these drugs may be subject to any copayments and deductibles that the health insurance policy applies generally to other prescription medication covered by the policy.

These requirements do not apply to a policy that covers only certain specified diseases, is issued by a limited service health organization, or is a Medicare supplement or Medicare replacement policy.
[s. 632.895(9), Wis. Stat.]

**Lead Screening**

All health insurance policies and all self-insured plans offered by a city, village, or school district are required to provide coverage for blood lead tests for children under 6 years of age, according to screening protocols established by the Department of Health Services.

This requirement does not apply to a policy that covers only certain specified diseases, policies offered by a limited service health organization, long-term care insurance policies, Medicare supplement policies, or Medicare replacement policies.
[ss. 609.85 and 632.895 (10), Wis. Stat.]

**TMJ Disorders**

All group and individual health insurance policies issued or renewed on or after January 1, 1998, that provide coverage of any diagnostic or surgical procedure involving a bone, joint, muscle, or tissue are required to provide coverage for diagnostic procedures and medically necessary surgical or nonsurgical treatment (including prescribed intraoral splint therapy devices) for the correction of temporomandibular (TMJ) disorders.

This applies to both group and individual policies, except dental-only and Medicare supplement policies, including HMOs, PPPs, and LSHOs, and every self-funded county, municipality, or school district health plan. [ss. 609.78 and 632.895 (11), Wis. Stat.]

All health insurance policies issued or renewed on or after June 17, 1998, may cap coverage of nonsurgical diagnosis and treatment of TMJ at $1,250 per year. Plans are permitted to impose a prior authorization requirement on surgical or nonsurgical TMJ services, but not diagnosis.

**Hospital and Ambulatory Surgery Center Charges and Anesthetics for Dental Care**

Health policies that are issued or renewed on or after January 1, 1998, are required to cover hospital or ambulatory surgery center charges incurred and anesthetics provided in conjunction with dental care if **any** of the following applies:

1. The individual is a child under the age of 5
2. The individual has a chronic disability that meets all the conditions in s. 230.04 (9r) (a) 2. a., b., and c., Wis. Stat.
3. The individual has a medical condition that requires hospitalization or general anesthesia for dental care.

This applies to both group and individual policies, including HMOs, PPPs, and LSHOs, and every self-funded county, municipality and school district health plan. [ss. 609.79 and 632.895 (12), Wis. Stat.]

This requirement does not apply to dental-only plans issued or renewed on or after June 17, 1998.

**Breast Reconstruction**

Health insurance policies that are issued or renewed on or after January 1, 1998, that provide coverage for a mastectomy are required to provide coverage of breast reconstruction of the affected tissue incident to a mastectomy.

This applies to both group and individual policies, including HMOs, PPPs, and LSHOs, and every self-funded county, municipality and school district health plan. [ss. 609.77 and 632.895 (13), Wis. Stat.]

**Child Immunizations**

All health insurance policies that are issued or renewed on or after November 1, 2000, and every self-insured health plan of the state or of a county, city, town, village, or school district that provides coverage for a dependent of an insured, must provide

coverage of appropriate and necessary immunizations from birth to the age of 6 years for a dependent who is a child of the insured. The coverage may not be subject to any deductibles, copayments or coinsurance under the policy or plan, except that a managed care plan is prohibited from applying such cost-sharing only with respect to services provided by network providers.

The mandate does not apply to health insurance policies that provide coverage of only certain specified diseases, policies that cover only hospital and surgical charges, policies offered by a limited service health organization, long-term care policies, and Medicare supplement or Medicare replacement policies. [s. 632.895 (14), Wis. Stat.]

**Coverage of Certain Health Care Costs in Cancer Clinical Trials**

Health care policies, plans, and contracts are prohibited from excluding coverage for certain health care services, items, or drugs administered to an insured in a cancer clinical trial in certain situations that would be covered under the policy, plan, or contract if the insured were not enrolled in a cancer clinical trial. The coverage is subject to all terms, conditions and restrictions that apply to other coverage under the policy, including the treatment and services performed by participating and nonparticipating providers. This includes policy requirements that the cancer clinical trial services be performed by a participating provider.

These changes apply to insurance policies issued or renewed on or after November 1, 2006, and self-insured health plans of the state or of a county, city, village, town, or school district, established, extended, modified, or renewed on or after November 1, 2006. However, if an insurance policy covers employees under a collective bargaining agreement containing provisions inconsistent with these changes, the changes first apply to a policy issued or renewed on the earlier of: (a) the date the collective bargaining agreement expires; or (b) the date the collective bargaining agreement is extended, modified, or renewed. If a self-insured plan covers employees under a collective bargaining agreement containing provisions inconsistent with the changes, the changes first apply to a plan established, extended, modified, or renewed on the earlier of: (a) the date the collective bargaining agreement expires; or (b) the date the collective bargaining agreement is extended, modified, or renewed.

[ss. 40.51 (8), 66.0137 (4), 120.13 (2) (g), 185.981 (4t), 185.983 (1) (intro.), 632.855 (2) (intro.) 632.855 (3), and 632.855 (3) (bm), 632.87 (1), and 632.87 (6), Wis. Stat.]

**Coverage of Student on Medical Leave**

Every disability insurance policy and every self-insured health plan of the state or of a county, city, town, village, or school district that provides coverage for a person as a dependent of the insured because the person is a full-time student shall continue to provide dependent coverage for the person if, due to a medically necessary leave of absence, he or she ceases to be a full-time student.

A student is required to submit documentation and certification from the person's attending physician stating the medical necessity of the leave of absence.

This applies to insurance policies issued or renewed on or after July 1, 2008, and self-insured health plans of the state or of a county, city, village, town, or school district, established, extended, modified, or renewed on or after July 1, 2008. However, if an insurance policy covers employees under a collective bargaining agreement containing provisions inconsistent with this provision, it first applies to a policy issued or renewed on the earlier of: (a) the date the collective bargaining agreement expires; or (b) the date the collective bargaining agreement is extended, modified, or renewed. If a self-insured plan covers employees under a collective bargaining agreement containing provisions inconsistent with this provision, it first applies to a plan established, extended, modified, or renewed on the earlier of: (a) the date the collective bargaining agreement expires; or (b) the date the collective bargaining agreement is extended, modified, or renewed.

[ss. 40.51 (8), 40.51 (8m), 66.0137 (4), 111.91 (2) (nm), 120.13 (2) (g), 185.981 (4t), 185.983 (1) (intro.), 609.76, and 632.895 (15), Wis. Stat.]

**Health Insurance Coverage of Dependents**

Insurers that offer individual or group disability insurance policies (including vision and dental plans, but not hospital indemnity, income continuation, accident only, long-term care, and Medigap policies), and self-insured health plans of the state or of a county, city, village, town, or school district are required to provide coverage if requested to an adult child of the applicant or insured as a dependent of the applicant or insured if all of the following conditions are met:

- The child is over age 17 but less than 27 years of age.
- The child is not married, and the child is either not eligible for coverage under a group health benefit plan offered by his or her employer, or if

eligible for coverage, the child's premium contribution for the coverage is greater than the premium amount required to provide coverage to the child as a dependent under the parent's plan.

Provided the other conditions are still met, coverage must be provided to an adult child regardless of age if the child was under 27 years of age when he or she was called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the child was attending, on a full-time basis, an institution of higher education and the child returns to school as a full-time student within 12 months of fulfilling his or her active duty obligation.

An insurer or self-insured plan is required to determine the premium for coverage of an adult child who is over 18 on the same basis as the premium is determined for a dependent who is 17 years of age or younger.

An insurer or self-insured health plan may require an applicant or an insured seeking coverage of an adult child to provide written documentation initially and annually thereafter that the adult child meets the criteria to be covered as a dependent.

The state requirements above take effect for policies issued or renewed and governmental or school district self-insured health plans that are established, extended, modified or renewed, on or after January 1, 2010. Note there may be state tax implications for parents utilizing this benefit for their dependent children. [Section 632.885, Wis. Stat.]

Additionally, provisions in the federal Patient Protection and Affordable Care Act (PPACA) require coverage of adult children as dependents under their parents' plan or policy up to age 26 years of age. Both married and unmarried children qualify for this coverage. The federal requirement is effective for plan and policy years beginning on or after September 23, 2010, and applies to all plans in the individual market and to new employer plans. Group plans in existence on March 23, 2010, may exclude adult children who are eligible to enroll in an employer-sponsored health plan unless it is the group health plan of their parent. However, beginning with plan or policy years on or after January 1, 2014, children up to age 26 can stay on their parent's employer plan even if they have another offer of coverage through an employer.

**Autism Spectrum Disorder**

All disability insurance policies and self-insured health plans of the state or of a county, city, town, village, or school district are required to provide coverage for the treatment of autism spectrum disorders which includes autism disorder, Asperger's syndrome, and pervasive developmental disorder not otherwise specified. This provision does not apply to a disability policy that covers only certain specified diseases, a health care plan offered by a limited service health organization or by a preferred provider plan that is not a defined network plan, a long-term care insurance policy, or a Medicare replacement or a Medicare supplement policy.

Coverage must be provided for the treatment of autism spectrum disorders if the treatment is prescribed by a physician and provided by qualified providers. Coverage required includes at least $50,000 for intensive-level services per insured per year with a minimum of 30 to 35 hours of care per week for a minimum duration of 4 years and at least $25,000 for nonintensive-level services per insured per year.

Coverage may be subject to deductibles, coinsurance, or copayments that generally apply to other conditions covered by the policy or plan. The coverage may not be subject to limitations or exclusions, including limitations on the number of treatment visits.

The above provisions take effect for disability insurance policies that are issued or renewed and governmental or school district self-insured health plans that are established, extended, modified, or renewed on or after November 1, 2009. [s. 632.895 (12m), Wis. Stat.]

**Board Certified Behavior Analyst**

Behavior analysts are added to the list of providers that may provide physician-prescribed services for the treatment of autism spectrum disorders required to be covered by disability insurance policies and self-insured governmental and school district health plans. Paraprofessionals working under a behavior analyst's supervision are also covered. The Department of Regulation and Licensing (DRL) provides licensure and regulation of behavior analysts engaging in the practice of behavior analysis.

The above provisions took effect on May 26, 2010, except for the provisions regarding licensure of behavior analysts, which took effect on June 24, 2010.

**Contraceptive Coverage**

All disability insurance policies and self-insured health plans of the state or of a county, city, town,

village, or school district that provide coverage for outpatient health care services, preventive treatments and services, or prescription drugs and devices are required to also provide coverage for contraceptives prescribed by a health care provider, and outpatient consultations, examinations, procedures, and medical services that are necessary to prescribe, administer, maintain, or remove a contraceptive if covered for any other drug benefits under the policy or plan. Coverage may only be subject to the exclusions, limitations, or cost-sharing provisions that apply generally to the coverage of outpatient health care services, preventive treatment and services, or prescription drugs and devices that are provided under the policy or self-insured health plan.

These provisions do not apply to a disability policy that covers only certain specified diseases, a disability policy or self-insured health care plan that provides only limited-scope dental or vision benefits, a health care plan offered by a limited service health organization or by a preferred provider plan that is not a defined network plan, a long-term care insurance policy, or a Medicare replacement or a Medicare supplement policy.

The above provisions took effect for policies issued or renewed and governmental self-insured health plans that are established, extended, modified, or renewed on or after January 1, 2010. [s. 632.895 (17), Wis. Stat.]

**Cochlear Implants**

Coverage is required for hearing aids, cochlear implants, and related treatment for infants and children. This applies to group and individual disability policies and to self-insured health plans of the state or of a county, city, town, village, or school district newly issued or renewed on or after January 1, 2010.

The following coverage is provided:

- The cost of hearing aids and cochlear implants that are prescribed by a physician or by a licensed audiologist for a child covered under the policy or plan who is under 18 years of age and who is certified as deaf or hearing impaired by a physician or a licensed audiologist.

- The cost of treatment related to hearing aids and cochlear implants, including procedures for the implantation of cochlear devices, for a child as described above.

- The cost of hearing aids is not required to exceed the cost of one hearing aid per ear per child more than once every three years.

Coverage may be subject to any cost-sharing provisions, limitations, or exclusions, other than a preexisting condition exclusion, that apply generally under the disability insurance policy or self-insured health plan.

These provisions do not apply to a disability policy that covers only certain specified diseases, a disability policy or self-insured health care plan that provides only limited-scope dental or vision benefits, a health care plan offered by a limited service health organization or by a preferred provider plan that is not a defined network plan, a long-term care insurance policy, a Medicare replacement or a Medicare supplement policy, or a short-term individual health benefit plan.

The above provisions take effect for disability insurance policies that are issued or renewed and governmental or school district self-insured health plans that are established, extended, modified, or renewed on or after January 1, 2010.

**Colorectal Cancer Screening**

All disability insurance policies and self-insured health plans of the state or of a county, city, town, village, or school district that cover any diagnostic or surgical procedures are required to cover colorectal cancer examinations and laboratory tests for any insured or enrollee who is 50 years of age or older or any insured or enrollee who is under 50 years of age and at high risk for colorectal cancer.

Coverage may be subject to any cost-sharing provisions, limitations, or exclusions that apply generally under the disability insurance policy or self-insured health plan.

These provisions do not apply to a disability policy that covers only certain specified diseases other than cancer, a disability policy or self-insured health care plan that provides only limited-scope dental or vision benefits, or a health care plan offered by a limited service health organization or by a preferred provider plan that is not a defined network plan.

The Commissioner of Insurance, in consultation with the Secretary of the Department of Health Services and after considering nationally validated guidelines, including guidelines issued by the American Cancer Society for colorectal cancer screening, is required to promulgate rules that:

- Specify guidelines for colorectal cancer screening that must be covered under the law.

- Specify the factors for determining whether an individual is at high risk for colorectal cancer.

- Periodically update the guidelines and factors, described above.

The above provisions take effect for disability insurance policies that are issued or renewed and governmental or school district self-insured health plans that are established, extended, modified, or renewed on or after December 1, 2010. [s. 632.895 (16m), Wis. Stat.]

If you have a specific complaint about your insurance, refer it first to the insurance company or agent involved. If you do not receive satisfactory answers, contact the Office of the Commissioner of Insurance (OCI).

For information on how to file insurance complaints call:

(608) 266-0103 (In Madison)
or
1-800-236-8517 (Statewide)

Mailing Address
Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873

Electronic Mail
ocicomplaints@wisconsin.gov
Please indicate your name, phone number, and e-mail address.

OCI's World Wide Web Home Page
oci.wi.gov

**Deaf, hearing, or speech impaired callers may reach OCI through WI TRS**

A copy of OCI's complaint form is available on OCI's Web site. You can print it, complete it, and return it to the above mailing address.

Copies of OCI publications are available on-line on OCI's Web site.

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