632.895

Required coverage

(1) Definitions. In this section:

(a) "Disability insurance policy" means surgical, medical, hospital, major medical or other health service coverage but does not include hospital indemnity policies or ancillary coverages such as income continuation, loss of time or accident benefits.

(b) "Home care" means care and treatment of an insured under a plan of care established, approved in writing and reviewed at least every 2 months by the attending physician, unless the attending physician determines that a longer interval between reviews is sufficient, and consisting of one or more of the following:

1. Part-time or intermittent home nursing care by or under the supervision of a registered nurse.

2. Part-time or intermittent home health services that are medically necessary as part of the home care plan, under the supervision of a registered nurse or medical social worker, which consist solely of caring for the patient.

3. Physical or occupational therapy or speech-language pathology or respiratory care.

4. Medical supplies, drugs and medications prescribed by a physician and laboratory services by or on behalf of a hospital, if necessary under the home care plan, to the extent such items would be covered under the policy if the insured had been hospitalized.

5. Nutrition counseling provided by or under the supervision of one of the following, where such services are medically necessary as part of the home care plan:

a. A registered dietitian.

b. A dietitian certified under subch. V of ch. 448, if the nutrition counseling is provided on or after July 1, 1995.

6. The evaluation of the need for and development of a plan, by a registered nurse, physician extender or medical social worker, for home care when approved or requested by the attending physician.

(c) "Hospital indemnity policies" means policies which provide benefits in a stated amount for confinement in a hospital, regardless of the hospital expenses actually incurred by the insured, due to such confinement.

(d) "Immediate family" means the spouse, children, parents, grandparents, brothers and sisters of the insured and their spouses.

(2) Home care. (a) Every disability insurance policy which provides coverage of expenses incurred for inpatient hospital care shall provide coverage for the usual and customary fees for home care. Such coverage shall be subject to the same deductible and coinsurance provisions of the policy as other covered services. The maximum weekly benefit for such coverage need not exceed the usual and customary weekly cost for care in a skilled nursing facility. If an insurer provides disability insurance, or if 2 or more insurers jointly provide disability insurance, to an insured under 2 or more policies, home care coverage is required under only one of the policies.

(b) Home care shall not be reimbursed unless the attending physician certifies that:

1. Hospitalization or confinement in a skilled nursing facility would otherwise be required if home care was not provided.

2. Necessary care and treatment are not available from members of the insured's immediate family or other persons residing with the insured without causing undue hardship.

3. The home care services shall be provided or coordinated by a state-licensed or medicare-certified home health agency or certified rehabilitation agency.

(c) If the insured was hospitalized immediately prior to the commencement of home care, the home care plan shall also be initially approved by the physician who was the primary provider of services during the hospitalization.

(d) Each visit by a person providing services under a home care plan or evaluating the need for or developing a plan shall be considered as one home care visit. The policy may contain a limit on the number of home care visits, but not less than 40 visits in any 12-month period, for each person covered under the policy. Up to 4 consecutive hours in a 24-hour period of home health service shall be considered as one home care visit.

(e) Every disability insurance policy which purports to provide coverage supplementing parts A and B of Title XVIII of the social security act {Footnote 1} shall make available and if requested by the insured provide coverage of supplemental home care visits beyond those provided by parts A and B, sufficient to produce an aggregate coverage of 365 home care visits per policy year.

(f) This subsection does not require coverage for any services provided by members of the insured's immediate family or any other person residing with the insured.

(g) Insurers reviewing the certified statements of physicians as to the appropriateness and medical necessity of the services certified by the physician under this subsection may apply the same review criteria and standards which are utilized by the insurer for all other business.

(3) Skilled nursing care. Every disability insurance policy filed after November 29, 1979, which provides coverage for hospital care shall provide coverage for at least 30 days for skilled nursing care to patients who enter a licensed skilled nursing care facility. A disability insurance policy, other than a medicare supplement policy or medicare replacement policy, may limit coverage under this subsection to patients who enter a licensed skilled nursing care facility within 24 hours after discharge from a general hospital. The daily rate payable

under this subsection to a licensed skilled nursing care facility shall be no less than the maximum daily rate established for skilled nursing care in that facility by the department of health and family services for purposes of reimbursement under the medical assistance program under subch. IV of ch. 49. The coverage under this subsection shall apply only to skilled nursing care which is certified as medically necessary by the attending physician and is recertified as medically necessary every 7 days. If the disability insurance policy is other than a medicare supplement policy or medicare replacement policy, coverage under this subsection shall apply only to the continued treatment for the same medical or surgical condition for which the insured had been treated at the hospital prior to entry into the skilled nursing care facility. Coverage under any disability insurance policy governed by this subsection may be subject to a deductible that applies to the hospital care coverage provided by the policy. The coverage under this subsection shall not apply to care which is essentially domiciliary or custodial, or to care which is available to the insured without charge or under a governmental health care program, other than a program provided under ch. 49.

(4) Kidney disease treatment. (a) Every disability insurance policy which provides hospital treatment coverage on an expense incurred basis shall provide coverage for hospital inpatient and outpatient kidney disease treatment, which may be limited to dialysis, transplantation and donor-related services, in an amount not less than $30,000 annually, as defined by the department of health and family services under par. (d).

(b) No insurer is required to duplicate coverage available under the federal medicare program, nor duplicate any other insurance coverage the insured may have. Other insurance coverage does not include public assistance under ch. 49.

(c) Coverage under this subsection may not be subject to exclusions or limitations, including deductibles and coinsurance factors, which are not generally applicable to other conditions covered under the policy.

(d) The department of health and family services may by rule impose reasonable standards for the treatment of kidney diseases required to be covered under this subsection, which shall not be inconsistent with or less stringent than applicable federal standards.

(5) Coverage of newborn infants. (a) Every disability insurance policy shall provide coverage for a newly born child of the insured from the moment of birth.

(b) Coverage for newly born children required under this subsection shall consider congenital defects and birth abnormalities as an injury or sickness under the policy and shall cover functional repair or restoration of any body part when necessary to achieve normal body functioning, but shall not cover cosmetic surgery performed only to improve appearance.

(c) If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy may require that notification of the birth of a child and payment of the required premium or fees shall be furnished to the insurer within 60 days after the date of birth. The insurer 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 and in addition pays interest on such payments at the rate of 5 1/2 % per year.

(d) If 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.

(e) This subsection applies to all policies issued or renewed after May 5, 1976, and to all policies in existence on June 1, 1976. All policies issued or renewed after June 1, 1976, shall be amended to comply with the requirements of this subsection.

(5m) Coverage of grandchildren. Every disability insurance policy issued or renewed on or after May 7, 1986, that provides coverage for any child of the insured shall provide the same coverage for all children of that child until that child is 18 years of age.

(6) {Footnote 2} Equipment and supplies for treatment of diabetes. Every disability insurance policy which provides coverage of expenses incurred for treatment of diabetes shall provide coverage for expenses incurred by the installation and use of an insulin infusion pump, coverage for all other equipment and supplies, including insulin or any other prescription medication, used in the treatment of diabetes, and coverage of diabetic self-management education programs. Coverage required under this subsection shall be subject to the same exclusions, limitations, deductibles, and coinsurance provisions of the policy as other covered expenses, except that insulin infusion pump coverage may be limited to the purchase of one pump per year and the insurer may require the insured to use a pump for 30 days before purchase.

(7) Maternity coverage. Every group disability insurance policy which provides maternity coverage shall provide maternity coverage for all persons covered under the policy. Coverage required under this subsection may not be subject to exclusions or limitations which are not applied to other maternity coverage under the policy.

(8) Coverage of mammograms. (a) In this subsection:

1. "Direction" means verbal or written instructions, standing orders or protocols.

2. "Low-dose mammography" means the X-ray examination of a breast using equipment dedicated specifically for mammography, including the X-ray tube, filter, compression device, screens, films and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with 2 views for each breast.

3. "Nurse practitioner" means an individual who is licensed as a registered nurse under ch. 441 or the laws of another state and who satisfies any of the following:

a. Is certified as a primary care nurse practitioner or clinical nurse specialist by the American nurses' association or by the national board of pediatric nurse practitioners and associates.

am. Holds a master's degree in nursing from an accredited school of nursing.

b. Before March 31, 1990, has successfully completed a formal one-year academic program that prepares registered nurses to perform an expanded role in the delivery of primary care, includes at least 4 months of classroom instruction and a component of supervised clinical practice, and awards a degree, diploma or certificate to individuals who successfully complete the program.

c. Has successfully completed a formal education program that is intended to prepare registered nurses to perform an expanded role in the delivery of primary care but that does not meet the requirements of subd. 3.b., and has performed an expanded role in the delivery of primary care for a total of 12 months during the 18-month period immediately before July 1, 1978.

(b) 1. Except as provided in subd. 2 and par. (f), every disability insurance policy that provides coverage for a woman age 45 to 49 shall provide coverage for that woman of 2 examinations by low-dose mammography performed when the woman is age 45 to 49, if all of the following are satisfied:

a. Each examination by low-dose mammography is performed at the direction of a licensed physician or a nurse practitioner, except as provided in par. (e).

b. The woman has not had an examination by low-dose mammography within 2 years before each examination is performed.

2. A disability insurance policy need not provide coverage under subd. 1 to the extent that the woman had obtained one or more examinations by low-dose mammography while between the ages of 45 and 49 and before obtaining coverage under the disability insurance policy.

(c) Except as provided in par. (f), every disability insurance policy that provides coverage for a woman age 50 or older shall provide coverage for that woman of an annual examination by low-dose mammography to screen for the presence of breast cancer, if the examination is performed at the direction of a licensed physician or a nurse practitioner or if par. (e) applies.

(d) Coverage is required under this subsection despite whether the woman shows any symptoms of breast cancer. Except as provided in pars. (b), (c) and (e), coverage under this subsection may only be subject to exclusions and limitations, including deductibles, copayments and restrictions on excessive charges, that are applied to other radiological examinations covered under the disability insurance policy.

(e) A disability insurance policy shall cover an examination by low-dose mammography that is not performed at the direction of a licensed physician or a nurse practitioner but that is otherwise required to be covered under par. (b) or (c), if all of the following are satisfied:

1. The woman does not have an assigned or regular physician or nurse practitioner when the examination is performed.

2. The woman designates a physician to receive the results of the examination.

3. Any examination by low-dose mammography previously obtained by the woman was at the direction of a licensed physician or a nurse practitioner.

(f) This subsection does not apply to any of the following:

1. A disability insurance policy that only provides coverage of certain specified diseases.

2. A health care plan offered by a limited service health organization, as defined in § 609.01(3).

3. A medicare replacement policy, a medicare supplement policy or a long-term care insurance policy.

(9) Drugs for treatment of HIV infection. (a) In this subsection, "HIV infection" means the pathological state produced by a human body in response to the presence of HIV, as defined in § 631.90(1).

(b) Except as provided in par. (d), every disability insurance policy that is issued or renewed on or after April 28, 1990, and that provides coverage of prescription medication shall provide coverage for each drug that satisfies all of the following:

1. 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.

2. 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.

3. 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.

(c) Coverage of a drug under par. (b) may be subject to any copayments and deductibles that the disability insurance policy applies generally to other prescription medication covered by the disability insurance policy.

(d) This subsection does not apply to any of the following:

1. A disability insurance policy that covers only certain specified diseases.

2. A health care plan offered by a limited service health organization, as defined in § 609.01(3).

3. A medicare replacement policy or a medicare supplement policy.

(10) Lead poisoning screening. (a) Except as provided in par. (b), every disability insurance policy and every health care benefits plan provided on a self-insured basis by a county board under § 59.52(11), by a city or village under § 66.0137(4), by a political subdivision under § 66.0137(4m), by a town under § 60.23(25), or by a school district under § 120.13(2) shall provide coverage for blood lead tests for children under 6 years of age, which shall be conducted in accordance with any recommended lead screening methods and intervals contained in any rules promulgated by the department of health and family services under § 254.158.

(b) This subsection does not apply to any of the following:

1. A disability insurance policy that covers only certain specified diseases.

2. A health care plan offered by a limited service health organization, as defined in § 609.01(3).

3. A long-term care insurance policy, as defined in § 600.03(28g).

4. A medicare replacement policy, as defined in § 600.03(28p).

5. A medicare supplement policy, as defined in § 600.03(28r).

(11) Treatment for the correction of temporomandibular disorders. (a) Except as provided in par. (e), every disability insurance policy, and every self-insured health plan of the state or a county, city, village, town or school district, that provides coverage of any diagnostic or surgical procedure involving a bone, joint, muscle or tissue shall provide coverage for diagnostic procedures and medically necessary surgical or nonsurgical treatment for the correction of temporomandibular disorders if all of the following apply:

1. The condition is caused by congenital, developmental or acquired deformity, disease or injury.

2. Under the accepted standards of the profession of the health care provider rendering the service, the procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition.

3. The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

(b) 1. The coverage required under this subsection for nonsurgical treatment includes coverage for prescribed intraoral splint therapy devices.

2. The coverage required under this subsection does not include coverage for cosmetic or elective orthodontic care, periodontic care or general dental care.

(c) 1. The coverage required under this subsection may be subject to any limitations, exclusions or cost-sharing provisions that apply generally under the disability insurance policy or self-insured health plan.

2. Notwithstanding subd. 1., the coverage required under this subsection for diagnostic procedures and medically necessary nonsurgical treatment for the correction of temporomandibular disorders may not exceed $1,250 annually.

(d) Notwithstanding par. (c)1., an insurer or a self-insured health plan of the state or a county, city, village, town or school district may require that an insured obtain prior authorization for any medically necessary surgical or nonsurgical treatment for the correction of temporomandibular disorders.

(e) This subsection does not apply to any of the following:

1. A disability insurance policy that covers only dental care.

2. A medicare supplement policy, as defined in § 600.03(28r).

(12) Hospital and ambulatory surgery center charges and anesthetics for dental care. (a) In this subsection, "ambulatory surgery center" has the meaning given in 42 CFR 416.2.

(b) Except as provided in par. (d), every disability insurance policy, and every self-insured health plan of the state or a county, city, village, town or school district, shall cover hospital or ambulatory surgery center charges incurred, and anesthetics provided, in conjunction with dental care that is provided to a covered individual in a hospital or ambulatory surgery center, 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 of the conditions under § 230.04(9r)(a)2. a., b. and c.

3. The individual has a medical condition that requires hospitalization or general anesthesia for dental care.

(c) The coverage required under this subsection may be subject to any limitations, exclusions or cost-sharing provisions that apply generally under the disability insurance policy or self-insured plan.

(d) This subsection does not apply to a disability insurance policy that covers only dental care.

(12m) {Footnote 3}

Treatment for autism spectrum disorders. (a) In this subsection:

1. "Autism spectrum disorder" means any of the following:

a. Autism disorder.

b. Asperger's syndrome.

c. Pervasive developmental disorder not otherwise specified.

2. "Insured" includes an enrollee and a dependent with coverage under the disability insurance policy or self-insured health plan.

3. "Intensive-level services" means evidence-based behavioral therapy that is designed to help an individual with autism spectrum disorder overcome the cognitive, social, and behavioral deficits associated with that disorder.

4. "Nonintensive-level services" means evidence-based therapy that occurs after the completion of treatment with intensive-level services and that is designed to sustain and maximize gains made during treatment with intensive-level services or, for an individual who has not and will not receive intensive-level services, evidence-based therapy that will improve the individual's condition.

5. "Physician" has the meaning given in § 146.34 (1)(g).

(b) Subject to pars. (c) and (d), and except as provided in par. (e), every disability insurance policy, and every self-insured health plan of the state or a county, city, town, village, or school district, shall provide coverage for an insured of treatment for the mental health condition of autism spectrum disorder if the treatment is prescribed by a physician and provided by any of the following who are qualified to provide intensive-level services or nonintensive-level services:

1. A psychiatrist, as defined in § 146.34 (1) (h).

2. A person who practices psychology, as described in § 455.01 (5).

3. A social worker, as defined in § 252.15 (1) (er), who is certified or licensed to practice psychotherapy, as defined in § 457.01 (8m).

4. A paraprofessional working under the supervision of a provider listed under subds. 1. to 3.

5. A professional working under the supervision of an outpatient mental health clinic certified under § 51.038.

6. A speech-language pathologist, as defined in § 459.20 (4).

7. An occupational therapist, as defined in § 448.96 (4).

(c) 1. The coverage required under par. (b) shall provide 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, except that these minimum coverage monetary amounts shall be adjusted annually, beginning in 2011, to reflect changes in the consumer price index for all urban consumers, U.S. city average, for the medical care group, as determined by the U.S. department of labor. The commissioner shall publish the new minimum coverage amounts under this subdivision each year, beginning in 2011, in the Wisconsin Administrative Register.

2. Notwithstanding subd. 1., the minimum coverage monetary amounts or duration required for treatment under subd. 1., need not be met if it is determined by a supervising professional, in consultation with the insured's physician, that less treatment is medically appropriate.

(d) The coverage required under par. (b) may be subject to deductibles, coinsurance, or copayments that generally apply to other conditions covered under the policy or plan. The coverage may not be subject to limitations or exclusions, including limitations on the number of treatment visits.

(e) This subsection does not apply to any of the following:

1. A disability insurance policy that covers only certain specified diseases.

2. A health care plan offered by a limited service health organization, as defined in § 609.01 (3), or by a preferred provider plan, as defined in § 609.01 (4), that is not a defined network plan, as defined in § 609.01 (1b).

3. A long-term care insurance policy.

4. A medicare replacement policy or a medicare supplement policy.

(f) 1. The commissioner shall by rule further define "intensive-level services" and "nonintensive-level services" and define "paraprofessional" for purposes of par. (b) 4. and "qualified" for purposes of providing services under this subsection. The commissioner may promulgate rules governing the interpretation or administration of this subsection.

2. Using the procedure under § 227.24, the commissioner may promulgate the rules under subd. 1. for the period before the effective date of the permanent rules promulgated under subd. 1., but not to exceed the period authorized under § 227.24 (1) (c) and (2). Notwithstanding § 227.24 (1) (a), (2) (b), and (3), the commissioner is not required to provide evidence that promulgating a rule under this subdivision as an emergency rule is necessary for the preservation of the public peace, health, safety, or welfare and is not required to provide a finding of emergency for a rule promulgated under this subdivision.

(13) Breast reconstruction. (a) Every disability insurance policy, and every self-insured health plan of the state or a county, city, village, town or school district, that provides coverage of the surgical procedure known as a mastectomy shall provide coverage of breast reconstruction of the affected tissue incident to a mastectomy.

(b) The coverage required under par. (a) may be subject to any limitations, exclusions or cost-sharing provisions that apply generally under the disability insurance policy or self-insured health plan.

(14) Coverage of immunizations. (a) In this subsection:

1. "Appropriate and necessary immunizations" means the administration of vaccine that meets the standards approved by the U.S. public health service for such biological products against at least all of the following:

a. Diphtheria.

b. Pertussis.

c. Tetanus.

d. Polio.

e. Measles.

f. Mumps.

g. Rubella.

h. Hemophilus influenza B.

i. Hepatitis B.

j. Varicella.

2. "Dependent" means a spouse, an unmarried child under the age of 19 years, an unmarried child who is a full-time student under the age of 21 years and who is financially dependent upon the parent, or an unmarried child of any age who is medically certified as disabled and who is dependent upon the parent.

(b) Except as provided in par. (d), every disability insurance policy, and every self-insured health plan of the state or a county, city, town, village or school district, that provides coverage for a dependent of the insured shall 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.

(c) The coverage required under par. (b) may not be subject to any deductibles, copayments, or coinsurance under the policy or plan. This paragraph applies to a defined network plan, as defined in § 609.01(1b), only with respect to appropriate and necessary immunizations provided by providers participating, as defined in § 609.01(3m), in the plan.

(d) This subsection does not apply to any of the following:

1. A disability insurance policy that covers only certain specified diseases.

2. A disability insurance policy that covers only hospital and surgical charges.

3. A health care plan offered by a limited service health organization, as defined in § 609.01(3), or by a preferred provider plan, as defined in § 609.01(4), that is not a defined network plan, as defined in § 609.01(1b).

4. A long-term care insurance policy, as defined in § 600.03(28g).

5. A medicare replacement policy, as defined in § 600.03(28p).

6. A medicare supplement policy, as defined in § 600.03(28r).

(15) Coverage of student on medical leave. (a) Subject to pars. (b) and (c), every disability insurance policy, and every self-insured health plan of the state or 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, including the coverage under § 632.885 (2) (b), 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.

(b) A policy or plan is not required to continue coverage under par. (a) unless the person submits documentation and certification of the medical necessity of the leave of absence from the person's attending physician. The date on which the person ceases to be a full-time student due to the medically necessary leave of absence shall be the date on which the coverage continuation under par. (a) begins.

(c) A policy or plan is required to continue coverage under par. (a) only until any of the following occurs:

1. The person advises the policy or plan that he or she does not intend to return to school full time.

2. The person becomes employed full time.

3. The person obtains other health care coverage.

4. The person marries and is eligible for coverage under his or her spouse's health care coverage.

5. Except for a person who has coverage as a dependent under § 632.885 (2) (b), the person reaches the age at which coverage as a dependent who is a full-time student would otherwise end under the terms and conditions of the policy or plan.

6. Coverage of the insured through whom the person has dependent coverage under the policy or plan is discontinued or not renewed.

7. One year has elapsed since the person's coverage continuation under par. (a) began and the person has not returned to school full time.

Text of subsections (16) and (17) effective January 1, 2010

(16) Hearing aids, cochlear implants, and related treatment for infants and children. (a) In this subsection:

1. "Cochlear implant" includes any implantable instrument or device that is designed to enhance hearing.

2. "Hearing aid" means any externally wearable instrument or device designed for or offered for the purpose of aiding or compensating for impaired human hearing and any parts, attachments, or accessories of such an instrument or device, except batteries and cords.

3. "Physician" has the meaning given in Section 448.01 (5).

4. "Self-insured health plan" means a self-insured health plan of the state or a county, city, village, town, or school district.

5. "Treatment" means services, diagnoses, procedures, surgery, and therapy provided by a health care professional.

(b) 1. Except as provided in par. (c), every disability insurance policy and every self-insured health plan shall provide the following coverages:

a. Coverage of the cost of hearing aids and cochlear implants that are prescribed by a physician, or by an audiologist licensed under subch. II of ch. 459, in accordance with accepted professional medical or audiological standards, 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 by an audiologist licensed under subch. II of ch. 459.

b. Coverage of the cost of treatment related to hearing aids and cochlear implants, including procedures for the implantation of cochlear devices, for a child specified in subd. 1. a.

2. Coverage of the cost of hearing aids under this subsection is not required to exceed the cost of one hearing aid per ear per child more often than once every 3 years.

3. The coverage required under this subsection 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.

(c) This subsection does not apply to any of the following:

1. A disability insurance policy that covers only certain specified diseases.

2. A disability insurance policy, or a self-insured health plan of the state or a county, city, town, village, or school district, that provides only limited-scope dental or vision benefits.

3. A health care plan offered by a limited service health organization, as defined in Section 609.01 (3), or by a preferred provider plan, as defined in Section 609.01 (4), that is not a defined network plan, as defined in Section 609.01 (1b).

4. A long-term care insurance policy.

5. A medicare replacement policy or a medicare supplement policy.

5m. An individual health benefit plan that is not renewable and that has a specified termination date that, including any extensions that the policyholder may elect without the insurer's consent, is less than 12 months after the original effective date.

(17) {Footnote 4}

Contraceptives and services. (a) In this subsection, "contraceptives" means drugs or devices approved by the federal food and drug administration to prevent pregnancy.

(b) 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 of outpatient health care services, preventive treatments and services, or prescription drugs and devices shall provide coverage for all of the following:

1. Contraceptives prescribed by a health care provider, as defined in § 146.81 (1).

2. 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.

(c) Coverage under par. (b) may be subject only to the exclusions, limitations, or cost-sharing provisions that apply generally to the coverage of outpatient health care services,

preventive treatments and services, or prescription drugs and devices that is provided under the policy or self-insured health plan.

(d) This subsection does not apply to any of the following:

1. A disability insurance policy that covers only certain specified diseases.

2. A disability insurance policy, or a self-insured health plan of the state or a county, city, town, village, or school district, that provides only limited-scope dental or vision benefits.

3. A health care plan offered by a limited service health organization, as defined in § 609.01 (3), or by a preferred provider plan, as defined in § 609.01 (4), that is not a defined network plan, as defined in § 609.01 (1b).

4. A long-term care insurance policy.

5. A Medicare replacement policy or a Medicare supplement policy.

{Footnote 1}42 U.S.C. § 1395 et seq.

{Footnote 2}Pursuant to 2001 Act 82 (SB 250), § 3:

"This act first applies to all of the following:

"(a) Except as provided in paragraphs (b) and (c), disability insurance policies that are issued or renewed on the effective date of this paragraph.

"(b) Disability insurance policies covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are issued or renewed on the earlier of the following:

"1. The day on which the collective bargaining agreement expires.

"2. The day on which the collective bargaining agreement is extended, modified, or renewed.

"(c) Self-insured health plans covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are established, extended, modified, or renewed on the earlier of the following:

"1. The day on which the collective bargaining agreement expires.

"2. The day on which the collective bargaining agreement is extended, modified, or renewed."

{Footnote 3}Pursuant to 2009, AB 75, § 9326(8L): "The treatment of sections ... 632.895 (12m) of the statutes first applies to all of the following:

{Footnote 4}Pursuant to 2009, AB 75, § 9326(9f): "The treatment of sections ... 632.895 (17) of the statutes first applies to all of the following: