



Consumer's Guide to Health Insurance and Worker's Compensation Insurance for Farm Families

This guide discusses three types of insurance coverage farm owners need to cover themselves, their families, and employees: health insurance, worker's compensation insurance, and disability income insurance.

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Disclaimer

This guide is intended as a general overview of current law in this area, but is not intended as a substitute for legal advice in any particular situation. You may want to consult your attorney about your specific rights. Publications are updated annually unless otherwise stated and, as such, the information in this publication may not be accurate or timely in all instances. Publications are available on OCI's website at oci.wi.gov/Publications. If you need a printed copy of a publication, use the online order form (oci.wi.gov/Pages/Consumers/Order-a-Publication.aspx) or call 1-800-236-8517. One copy of this publication is available free of charge to the general public. All materials may be printed or copied without permission.

File a Complaint

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).

- Reach out to OCI (1-800-236-8517, ocicomplaints@wisconsin.gov) to speak with our staff. If sending an email, please indicate your name and phone number.
- File a complaint with OCI. You can file a complaint online at oci.wi.gov/complaints. If you would like to file your complaint by mail, visit oci.wi.gov/complaints, email ocicomplaints@wisconsin.gov, or call 1-800-236-8517 for a form.

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Types of Insurance

This publication describes three types of [insurance coverage](#) farm owners may need to cover themselves, their families, and employees:

- **Health Insurance**
Provides coverage for the medical treatment of sicknesses and injuries. It does not generally provide coverage for work-related injuries.
- **Worker's Compensation Insurance**
Provides coverage for work-related injuries including medical treatment and lost wages. As employers, some farmers provide standard health insurance and worker's compensation insurance to employees.

- **Disability Income Insurance**

Provides coverage for lost wages because of a short-term (short-term disability) or long-term (long-term disability) illness or injury. Farmers may purchase disability income insurance for themselves and for their employees.

Health Insurance

Health insurance generally provides payment for medical treatment and hospital stays. It often is available on a group basis through an employer, union, or association. In other cases, people buy individual [policies](#).

- **Group Health Insurance**

Group health insurance is often available if a farmer is an employer, an employee, or the dependent of an insured person. Group health insurance provides coverage to individuals under a single master policy issued to the group policy owner. [Certificates of insurance](#) are provided to the individuals. The policy owner may be an employer, an association, a labor union, or other entity. Insurers may require minimum employee or member participation levels in order to assure there are sufficient individuals in the group in good health to balance those in the group in poorer health.

- **Trust Groups**

Farmers, as farm owners or employers, also may have the option of enrolling in farm insurance association/ trust groups, which are offered through the Farm Bureau Association or local dairy cooperative. These trust groups provide coverage for a pool of employers. Plans may offer comprehensive major medical coverage. Farms that are subsidiaries or affiliates of employers participating in the trust and employees of such subsidiaries or affiliates may also be eligible under the trust policy.

- **Individual Health Insurance**

Farmers not qualifying for group health insurance may want to buy individual health coverage. Individual health insurance provides coverage to a specific individual or to an individual and his or her family under a policy issued to that individual. Most individual policies have exclusions for work-related injuries including injuries occurring while working on a farm.

Finding adequate coverage at an affordable price will take some effort. Start with a knowledgeable health insurance agent who will provide reliable service. Your agent can explain the policy limitations and [exclusions](#) which might apply. You may also consider recommendations from family or friends.

Choosing a Plan

Choosing a health insurance plan is like making any other major purchase. You choose the plan that meets both your needs and your budget. For most people, this means deciding which plan is worth the cost.

Health insurance plans are usually described as a [fee-for-service](#) health plan or a [managed care health plan](#). A fee-for-service health plan allows you to use any doctor, hospital, or other provider you choose. Although these plans offer the greatest freedom to select any doctor, they are usually more expensive than plans which limit choices. Managed care health plans usually cost less but give less freedom of choice.

The cost of [premiums](#) is not the only thing to consider when buying health insurance. You also need to consider what cost-sharing, such as [deductibles](#), [coinsurance](#) and [copayments](#), will be applied. Compare plans carefully for both premium cost and [out-of-pocket](#) cost-sharing expenses.

Features Included in Most Health Plans

- **Deductible**

In almost all plans, you must meet a deductible. The deductible is the dollar amount you must pay each year before the insurance company pays its share.

If you are buying coverage for your family, ask how the family plan works. Family plans may have family and individual deductibles that need to be paid before the health plan pays towards your family's medical expenses.

Read the policy carefully. Some policies require you to pay a deductible on a calendar year basis or on an individual sickness or injury basis.

- **Coinsurance**

Coinsurance is your share or the percentage of covered expenses you must pay in addition to the deductible. The most common coinsurance arrangement is for the insurance company to pay 80% and you pay 20% as coinsurance until a maximum out-of-pocket expense is reached. Coinsurance applies to each person and starts over again each year. Sometimes the policy will cover all expenses after a certain point.

- **Out-of-Pocket Limit**

Many plans have an out-of-pocket limit. The out-of-pocket limit is the maximum dollar amount you pay for covered services and supplies during a specified period, generally a calendar year. The maximum may be defined to include or exclude the deductible and can be separate based on whether services are in or out of [network](#). Once the out-of-pocket maximum is paid, benefits are paid at 100% of the covered costs incurred after that time.

Medically Necessary

Every health insurance policy contains a provision which allows insurance companies to evaluate whether a service or treatment is "[medically necessary](#)" in treating a patient and whether it could adversely affect the patient's condition if it were omitted. Insurance companies can deny payment for a treatment not medically necessary. Most health benefit plans require a review before certain medical procedures are conducted.

Usual, Customary, and Reasonable Charge

Most insurance companies do not use your actual bills to calculate their payments. They have their own fee schedule, such as a usual, customary, and reasonable (UCR) fee schedule. The UCR payments are typical amounts paid for everything from a doctor's visit to heart surgery.

For example, if your doctor charges \$1,000 for an operation while most doctors in your area charge only \$800, you will be billed for the \$200 difference. This is in addition to the deductible and coinsurance you would be expected to pay. To avoid this additional cost, ask your doctor to accept your insurance company's payment as full payment or shop around to find a doctor who will. Otherwise, you will pay the difference.

Exclusions and Limitations

There are some services plans will not cover—usually because they are not considered medically necessary. In addition, some services may be limited. You should review and compare each plan's exclusions and limitations. Keep in mind you must pay the full cost of care that is not covered.

Finding the Right Coverage

Before you make your decision on the health insurance policy to purchase, you need to shop and compare and to become familiar with the terms of a health insurance policy.

- Know the policy's deductibles, copayments, and maximum annual and lifetime payouts. Ask if there are different out-of-pocket expenses for different kinds of care, such as specialty services or prescriptions drugs.

- Request a complete explanation of the policy's provisions for [preexisting conditions](#) or waivers of coverage for specific medical conditions. Find out exactly what coverage you have for illnesses you had before you bought the policy.
- Ask about renewability. A [guaranteed renewable](#) policy protects you from cancellation or nonrenewal of the policy because of too many [claims](#).
- Read the fine print. Be aware of the circumstances under which a policy will and will not cover some services. Ask specifically about limitations and exclusions on experimental procedures, transplants, drug therapies, [durable medical equipment](#), and whether the policy covers farm or work-related accidents.
- Check on whether the policy covers actual or reasonable expenses. There can be quite a gap between actual and reasonable expenses.

When shopping for health insurance coverage, consider your health insurance needs. A bare-bones policy may or may not be for you. It might be wise to spend your health care dollars on one comprehensive major medical policy. Extra policies probably are not necessary. If you need more coverage, some health plans allow you to add benefits. If one policy costs less than another, it usually provides fewer benefits, may be too limited to be your sole health care coverage, and may duplicate coverage you already have.

Important Note: In the case of individual coverage, state law requires a 10-day "[free look](#)." You may change your mind and receive a refund if you return the individual policy within the free-look period. This period starts when you receive the policy. If you return the policy, send it by certified mail, return receipt requested. This gives you a record of the return date in case a dispute arises. Note, state law does not require a free-look period for group insurance coverage.

You should also consider whether a fee-for-service policy or managed care plan best meets the needs of your family. Both cover an array of medical, surgical, hospital expenses, and prescription drugs. They may include coverage for dentists and other providers. However, there are many important differences between fee-for-service and managed care plans.

Fee-for-Service Health Plan

Under a fee-for-service health plan, you are free to seek necessary medical care from any doctor and hospital you wish. The doctor often bills the insurance company directly for the services provided, and the insurance company pays for the items covered by the policy. In some cases you will have to fill out claim forms and send them to the insurance company. This type of health plan offers the most choices of doctors and hospitals.

Managed Care Health Plan

A health benefit plan is considered a Managed Care Health Plan if it offers enrollees incentives to use [network providers](#). Some managed care plans provide coverage only if the enrollee uses network providers and other plans will pay a larger portion of the charges if the enrollee uses network providers. Health maintenance organizations, point-of-service plans and preferred provider plans are examples of managed care plans.

Health Maintenance Organization (HMO)

An HMO is a health insurance plan providing comprehensive, prepaid medical care. It differs from a traditional insurer because it pays for and provides the medical care. An HMO often operates on a closed panel basis.

This means the enrollees are required to seek care from a medical provider who is either employed by or under contract to the HMO.

Except for serious emergencies or the need for [urgent care](#) outside the [service area](#), the HMO will probably not pay for care enrollees receive from a provider who is not affiliated with the HMO unless the HMO physician refers the enrollee to that provider and the HMO approves the referral.

Point-of-Service Plan (POS)

POS plans are essentially HMOs that allow members to use services by providers who are not in their health plan's network. In most cases, enrollees select a [primary care provider](#) and will need a [referral](#) to see a specialist. However, enrollees will have to pay more for using out-of-network providers.

Preferred Provider Plan (PPP)

A PPP is a form of managed care closest to a fee-for-service plan. A PPP has arrangements with doctors, hospitals, and other providers of care who have agreed to accept lower fees from the insurer for their services. A PPP pays a specific level of benefits if certain providers are used and a lesser amount if non-PPP providers are utilized. A PPP must provide reasonable access to network providers in the service area. However, a PPP is not required to offer a choice of participating providers in each geographic area.

PPPs may require enrollees pay coinsurance of up to 50% for services provided by nonparticipating providers.

Special Features of a Managed Care Plan

The following section discusses how a [defined network health plan](#) works.

Provider Directories

All managed care plans will provide an enrollee with access to a provider directory listing hospitals, primary care physicians, and specialty providers from whom the enrollee may obtain services. These directories are generally available on the plan's website, but a paper copy must be provided upon request. Enrollees should inquire with the health plan at the time of making an appointment as to whether the provider is currently a member of the defined network organization.

Continuity of Care

If a managed care plan represented a primary care physician (defined as a physician specializing in internal medicine, pediatrics, or family practice) as being available during an open enrollment period, it must make the physician available at no additional cost for the entire plan year. A specialist provider must be made available for the lesser of the course of treatment or 90 days. If an enrollee is in her second trimester of pregnancy, the provider must be available through postpartum care. The exceptions are for a provider who is no longer practicing in the managed care plan's service area or who was terminated from the plan for misconduct.

Referral Procedure

A managed care plan may not require a referral from a physician for services from a plan chiropractor. It must also allow a woman to receive obstetrical and gynecological services from a plan physician who specializes in obstetrics or gynecology without requiring a referral from her primary care provider.

HMO plans must have a procedure allowing for standing referrals. A standing referral authorizes an enrollee to be seen by a specialist provider for a specific duration of time or specific number of visits without having to obtain a separate referral from the primary provider for each visit to the specialist.

Second Opinions

Every managed care plan must cover a second opinion from another provider within the defined network plan's provider network.

Requirements Applicable to All Health Benefit Plans

Emergency Care

Every health care plan offered in Wisconsin covering [emergency care](#), including managed care plans, must cover services required to stabilize a condition most people would consider to be an emergency without [prior authorization](#). Managed care plans are permitted to charge a reasonable copayment or coinsurance for this benefit.

Grievance Procedure

All health benefit plans are required to have an internal [grievance](#) procedure for use if you are not satisfied with the service you receive or you have a claim denied. The procedure must be set forth in the insurance contract and must also be provided in written notice.

The health benefit plan must provide you with complete and understandable information about how to use the grievance procedure. You also have the right to appear in person before the grievance committee and present additional information.

However, before filing a grievance, you may want to first contact the health plan with a question or complaint. Many complaints can be resolved quickly and require no further action.

You may also file a complaint with OCI instead of, before, or at the same time as filing with the health plan.

Health benefit plans are required to have a separate expedited grievance procedure for situations where the medical condition requires immediate medical attention. The procedure requires health plans to resolve an expedited grievance within 72 hours after receiving the grievance.

Health benefit plans are required to file a report with OCI listing the number of grievances they had in the previous year. A summary of this information for HMOs and PPPs is included in The Consumer's Guide to Managed Care Plans in Wisconsin. A copy is available on OCI's website at oci.wi.gov/Pages/Consumers/PI-044.aspx or call 1-800-236-8517 to request a copy.

Independent Review

If you are not satisfied with the outcome of the grievance, you have an additional way to resolve some disputes involving medical decisions. You or your authorized representative may request an Independent Review Organization (IRO) review your health plan's decision.

The [independent external review](#) process provides you with an opportunity to have medical professionals who have no connection to your health plan review your dispute. The IRO assigns your dispute to a clinical peer reviewer who is an expert in the treatment of your medical condition. The clinical peer reviewer is generally a board-certified physician or other appropriate medical professional. The IRO has the authority to determine whether the treatment should be covered by your health plan.

Your health plan should provide you with information on your right to request an independent review in its written materials and with its final written decision on your grievance. You may also call the health plan at its toll-free number and request information on independent review.

For more information on the independent review process, a copy of Fact Sheet on the Independent Review Process in Wisconsin is available on OCI's website at oci.wi.gov/Pages/Consumers/PI-203.aspx or call 1-800-236-8517 to request a copy.

The Affordable Care Act (ACA)

The ACA was signed into law in 2010 and includes provisions affecting the individual and small group insurance markets. The ACA created the federal Exchange, also known as the [federally facilitated marketplace \(FFM\)](#), which allows you to check your eligibility for government assistance programs, including any subsidies available to help pay for your health insurance. You can purchase the same plans at the same cost directly from the insurance company or a licensed agent. However, you can only obtain the federal subsidies through FFM.

The ACA includes a number of market reforms which may apply to farm owners who are considered small employers for insurance purposes. In Wisconsin, a small employer is defined as an employer with 50 or fewer employees. The ACA provides small employers with the right to purchase health insurance from any insurer offering coverage in the market regardless of the health status of the small employer's employees or dependents. These employees may not be subject

to preexisting condition exclusions. Also, health insurance rates may only differ based on employee age, composition of family, geographic area, and tobacco use.

Small employers with fewer than 25 full-time equivalent employees and paying average annual wages of below \$50,000 may qualify for a small business tax credit to offset some of the costs of health insurance premiums. The amount of tax credit is based on the size of the employer's business. The fewer employees an employer has the larger the tax credit the employer may be eligible for.

Essential Health Benefits

All ACA-compliant comprehensive individual and small group health insurance policies must include a set of health care services called [essential health benefits](#). These benefits include:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

In addition to health care services in these categories, all of Wisconsin's mandated benefits are considered essential health benefits and must be covered by ACA-compliant comprehensive individual and small group health insurance policies. Information on Wisconsin mandated benefits is available in the OCI publication Fact Sheet on Mandated Benefits in Health Insurance Policies online at oci.wi.gov/Pages/Consumers/PI-019.aspx.

Essential health benefits must be covered with no annual or lifetime dollar limits.

Open Enrollment

The ACA provides for an annual open enrollment period. The open enrollment period runs from November 1 through December 15 each year. The ACA also provides for special enrollment periods if you experience certain life events, including losing health coverage, moving, getting married, having a baby, or adopting a child.

Small employer health insurance is available in Wisconsin from several insurers and managed care plans. OCI issues a publication meant to help small employers understand their options and to provide a comparison of premium [rates](#) available in the small employer health insurance marketplace. A copy of Health Insurance for Small Employers and Their Employees is available on OCI's website at oci.wi.gov/Pages/Consumers/PI-206.aspx or call 1-800-236-8517 to request a copy.

Other Insurance Options

Medicare, Medigap Insurance, Medicare Advantage, and Medicaid

Medicare is the health insurance program administered by the federal [Centers for Medicare & Medicaid Services \(CMS\)](http://www.cms.gov) ([cms.gov](http://www.cms.gov)) for people 65 and over and for some people under 65 who are disabled. It pays many health care costs for eligible persons. A publication entitled Medicare and You is available free from any Social Security office. It gives a detailed explanation of Medicare.

Medicare was designed to increase access to health care and reduce its financial burden on older, retired, or disabled Americans. Although Medicare covers many health care costs, you still have to pay Medicare's coinsurance and deductibles. If you do not have adequate group insurance and are not eligible for Medicaid (described below), you may

want to buy an individual [Medicare supplement insurance policy](#), Medicare select policy, [Medicare Advantage insurance policy](#), or a Medicare cost insurance policy.

OCI publishes several consumer publications to assist seniors in their shopping for insurance. The publications should be used only as a guide. Copies of the publications are available on OCI's Consumer Publications website at [oci.wi.gov/Publications](#) or by calling 1-800-236-8517.

- Medicare Supplement Insurance Approved Policies List ([oci.wi.gov/Pages/Consumers/PI-010.aspx](#)) lists policies available in Wisconsin including benefits and current premiums.
- Medicare Advantage in Wisconsin ([oci.wi.gov/Pages/Consumers/PI-099.aspx](#)) explains options available to Medicare-eligible persons age 65 and over, and some Medicare-eligible disabled individuals under age 65, who are looking for information about the Medicare Advantage program.
- Wisconsin Guide to Health Insurance for People with Medicare ([oci.wi.gov/Pages/Consumers/PI-002.aspx](#)) explains Medicare and supplemental insurance to cover those expenses not paid by Medicare.

Medicaid, also known as Medical Assistance, is a government health care program paid for by state and federal governments. You may qualify for Medicaid if you are a citizen of the United States or an "eligible" person, meet the financial eligibility requirements, and are in one of the following categories:

- Age 65 or older
- Blind or disabled
- A caretaker of a deprived child. (A deprived child is a child who has one or both parents absent from the home or has both parents in the home but one parent is incapacitated, unemployed, or an offender working without pay. The caretaker must be a relative of the child to be covered by Medicaid.)
- Under age 19
- Pregnant

If you apply for Wisconsin Medicaid and are not eligible because your income is over the limit, you may still be able to receive Medicaid if you have high medical bills. Ask your local county Human or Social Services Department or certifying Tribal Agency ([dhs.wisconsin.gov/medicaid/contacts/index.htm](#)) about the Medicaid deductible program.

BadgerCare Plus

BadgerCare Plus is a health care coverage program for low-income Wisconsin residents. Children, pregnant women, and adults may apply. BadgerCare Plus does not have an open enrollment period. You may apply for the program at any time.

If you would like more information about BadgerCare Plus, visit [dhs.wisconsin.gov/forwardhealth](#) or call member services at 1-800-362-3002.

Other Types of Special Coverage

There are several other types of policies on the market but they are not substitutes for basic or major medical coverage.

Hospital Confinement Indemnity

This type of policy pays a fixed amount for each day in the hospital for a specified number of days. The amount may range from \$50 to \$150 a day or more. Sometimes benefits are not paid until you have been hospitalized for several days. Because the average hospital stay is about seven days, these policies are often not a good buy unless the daily benefit is quite high.

Long-term Care Policies

Neither Medicare nor medigap insurance policies provide coverage for long-term nursing home stays. There are several types of policies on the market covering long-term care. A Guide to Long-Term Care is available on OCI's website at [oci.wi.gov/Pages/Consumers/PI-047.aspx](#) or by calling 1-800-236-8517.

Specified Disease Policies

These policies cover a specific disease or group of diseases. The most common type is cancer insurance. If you already have comprehensive coverage, this coverage is not necessary.

Any insurer selling cancer insurance must give the publication A Shopper's Guide to Cancer Insurance (oci.wi.gov/Pages/Consumers/PI-001.aspx) to all applicants.

Vision & Dental Policies

These are policies that provide benefits only for vision or dental care. They should not be bought as substitutes for more comprehensive coverage.

Consumer Tips

- Shop around. Health insurance is expensive. If you are buying individual insurance, check with several agents and companies before making a final choice.
- Using the Health Care Coverage Worksheet at the end of this publication will give you a more accurate idea of what your actual policy premium will be.
- Be sure to get the Schedule of Benefits. This is a brief explanation of specific benefits and benefit limitations for covered services provided under the terms of the Certificate of Insurance.
- Buying several limited policies can be very expensive and you may not have the coverage you need.
- Never sign a blank application. Verify any information filled in by the agent.
- Make payments by check or money order payable to the insurance company or HMO, not to the agent. Insist on a signed receipt on the company's letterhead. Pay no more than two months premium and fees until you have received the policy, group certificate, or HMO subscriber certificate.
- Make sure you have the full name, address, and phone number for both the agent and the insurance company or HMO.
- Be careful about mail order policies and those sold door-to-door. You may need a local agent to help you with claims.
- Avoid duplicate coverage. Insurance companies often coordinate benefits so you may collect on only one policy.

Disability Income Insurance

Anyone who works should consider purchasing disability income insurance, which is designed to help replace income lost because of a long-term injury or illness. People of working age are more likely to become disabled than they are to die—making disability insurance at least as important as life insurance.

There are two types of disability income insurance available: short-term and long-term. Short-term will typically replace a portion of your salary from three to six months following the disability. Long-term will generally begin six months after your disability and can last a few years or even until retirement.

You have to be a wise consumer, look at the different products, and choose the product that best suits you. The place to start is by determining how much income you need to meet critical financial obligations. These include rent/mortgage, food, fuel/transportation, utilities, and loan obligations. A disability may also bring with it increased or additional expenses like health care costs, assistance with [daily activities](#), and even home modifications.

Disability income policies have [waiting periods](#) before benefits become payable. The waiting period starts after you have become disabled for a covered disability. The longer the waiting period, the lower the premium will be. The period of time benefits are payable can also vary considerably. Benefit periods may depend on whether the disability was

caused by an accident or illness. A long-term policy may provide for lifetime accident benefits and illness benefits to the age of 65. The longer the benefit period, the higher the premium will be.

What is Covered

The amount of monthly benefit provided by a disability income policy may be stated as a percentage of income or as a set dollar amount. The amount of benefit for which you can qualify is usually based on a percentage of your gross earnings, normally around 60%. A partial disability benefit may be provided, or may be available, on an optional basis.

Some policies may reduce your benefit by the amount you receive from social security or worker's compensation so your disability benefit and social security or worker's compensation benefits together will provide a specified income. Some companies will consider possible social security benefits when they decide the amount of benefits for which you qualify.

Occupational therapy and vocational rehabilitation benefits may also be provided by a disability income policy.

Things to Be Aware of Regarding Disability Insurance

A disability income policy generally requires you be totally disabled before benefits are paid. The definition of total disability varies from policy to policy. There are two different definitions used in disability policies. One definition is you are unable to perform your own occupation. The other definition is much more comprehensive requiring you are unable to perform any occupation (for which you are suited by education or experience). This distinction can be important for jobs requiring very specialized physical skills such as surgeons or loggers.

Some points to check:

- What is the definition of disability? Is it defined as inability to perform your current occupation or as inability to perform any occupation of which you are capable?
- Does it cover both injury and sickness? Is it for partial or total disability?
- When does coverage begin? Is it different for injury and sickness?
- How long will benefits be paid? What is the weekly or monthly benefit? Will your benefit amount adjust for inflation?
- How much of your income will be replaced?
- What does it cost?
- Is it guaranteed renewable?
- Is the issuing company strong financially?

Disability income policies may specify income benefits will not be paid to a disabled person if the disability results from certain causes. Check the policy for any exclusions or limitations that might apply. If you have any questions, ask your agent.

You should not assume social security benefits will take care of you if you become disabled. Social Security provides long-term disability benefits based on pay and how long you have worked, but the benefits usually are smaller and administered very strictly. In order to qualify, a person must have a disability expected to last for at least one year or result in death.

Determining whether you need disability insurance is a personal choice. You must decide how much financial risk you are willing to assume should you suddenly find yourself unable to work for an extended period. How many months can you rely on your savings? How easy will it be for you to rebuild your retirement savings? Can your spouse's income cover the lost salary?

Worker's Compensation Insurance

Farmers and their dependents may find themselves financially ruined if they are injured on the farm and discover their health insurance company will not pay the claim because the accident was work-related and should be covered by worker's compensation.

In 1911, Wisconsin adopted The Worker's Compensation Act (Act). The intent of the law was to require an employer to promptly and accurately compensate a worker for any injury suffered on the job, regardless of the existence of any fault or whose it might be.

The Act limits the amount a worker can recover. Workers are entitled to certain wage loss benefits, the cost of medical treatment, and certain disability payments. Recovery under worker's compensation is limited to these three areas, no matter how serious the injury.

Worker's compensation is a system of no-fault insurance which pays benefits to employees for accidental injuries or diseases related to the employee's work.

Worker's compensation insurance is unique because the named [insured](#) is not the direct recipient of the policy benefits. Employees receive benefits paid by the insurer on behalf of the employer who is the named insured.

Benefits Under Worker's Compensation Insurance

Worker's compensation benefits can provide urgently needed medical care and can provide the needed financial support for farmers and their families. Basic benefits include:

1. Coverage of all reasonable and necessary medical costs.
2. Benefits for temporary wage loss [Temporary Partial Disability (TPD) or Temporary Total Disability (TTD)] sustained by an employee while recovering from injury. Eligibility for temporary disability benefits is determined and must be documented by a doctor. Benefits for temporary wage loss due to disability are based on two-thirds of the employee's wage rate up to a specified maximum amount.
3. Benefits for permanent disability [Permanent Partial Disability (PPD) or Permanent Total Disability (PTD)] if the employee does not fully recover from the injury. Permanent disability is awarded for the potential, or actual, loss of earning capacity. The amount of benefit payment for permanent disability depends on the seriousness of the permanent disability.
4. Vocational rehabilitation and retraining. For information on job retraining or placement, call or write the Worker's Compensation Division ([page 19](#)).

Temporary Disability

Eligibility for temporary disability benefits is determined and must be managed by the doctor. Benefits for temporary wage loss due to disability are based on two-thirds of the employee's wage rate up to a specified maximum amount.

Permanent Disability

When an employee's/patient's condition has leveled off and the prospect for future improvement is unlikely, the doctor usually declares a "healing plateau" has been reached. The patient is then evaluated for any residual permanent disability, generally referred to as a Permanent Partial Disability (PPD) rating. Permanent disability is awarded for the potential, or actual, loss of earning capacity. The amount of benefit payment for permanent disability depends on the seriousness of the permanent disability.

Death Benefits

Worker's compensation insurance also provides benefits if a work-related death occurs to an injured employee, death and burial expense will be paid up to specific limits.

If you have any questions regarding worker's compensation insurance benefits paid to an injured employee or if you have a specific complaint, contact information is available on [pages 19-20](#).

Worker's Compensation and Farming in Wisconsin

Anyone engaged in farming who employs six or more persons (at one or more locations) on any 20 consecutive or nonconsecutive days during a calendar year must have worker's compensation insurance. The insurance must be in place 10 days after the 20th day of employment has been reached. A calendar year is defined as January through December. Some relatives of the farmer are not counted as employees.

There is no wage threshold for farmers. It does not matter how much a farmer pays in wages. What matters is the number of employees (after excluding certain employees who are family members, relatives, or "exchanged workers").

Relatives are defined as the parents, spouse, child, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law of a farmer. If the farm is a sole proprietorship, a partnership, or a limited liability company, relatives are not considered to be or counted as employees of the farmer.

If the farm is a family farm corporation, all shareholders must be related as lineal ancestors or descendants. Shareholders of the family farm corporation do not count as employees of the farm. Relatives of a shareholder, as defined above, are not considered to be or counted as employees of the family farm corporation. All other employees are counted as employees.

If a farm is a corporation, where all shareholders are not related, all employees, including relatives, are considered to be and counted as employees.

For purposes of counting six or more employees, farmers or their employees working on an exchange basis are not to be counted as employees of the farmer to whom their labor is being furnished in exchange. However, these individuals may qualify for worker's compensation benefits if they sustain an injury while at work on an exchange basis and the farmer employer is already subject to the law.

Definition of Farmer - s. 102.04 (1) (c), Wis. Stat. Definition of Farming - s. 102.04 (3), Wis. Stat.

Definition of Employee of a Farmer - s. 102.07 (5) (a), (b), and (c), Wis Stat.

Obtaining Worker's Compensation Insurance

Private Insurance

There are about 300 insurance companies licensed to write worker's compensation insurance in Wisconsin. Contact a local agent to assist you in applying for insurance to the company of your choice.

If an insurance company turns down your application for insurance, you should ask your agent to search the marketplace for another company. A list of the insurers offering worker's compensation insurance is in the Wisconsin Compensation Rating Bureau's Annual Reports. Go to wcrb.org and click on the "Annual Reports" tab.

Wisconsin Worker's Compensation Pool

If coverage is not available in the private market, your agent may submit an application to the Wisconsin Compensation Rating Bureau (Bureau). The Bureau acts as administrator and trustee of the Wisconsin Worker's Compensation Insurance Pool (Pool). The Pool is a [risk](#)-sharing plan created to provide worker's compensation insurance to any insured who is unable to obtain coverage in the private market and who is, in good faith, entitled to such insurance. Out-of-state employers who do not have Wisconsin operations and Wisconsin employers who owe the Pool monies from prior policies are not eligible for coverage.

All insurers licensed to write worker's compensation insurance in Wisconsin must participate in the Pool, and are represented by four private insurance companies designated as servicing carriers. These companies write policies in their own name and provide claims, loss control, auditing, and other services, just as they would for their voluntarily underwritten policyholders.

Penalty for not Providing Coverage

The penalty for failure to carry worker's compensation insurance when required is twice the amount of premium not paid during an uninsured time period or \$750, whichever is greater. Under certain circumstances, an employer who has a lapse in worker's compensation insurance coverage can be subject to a penalty of \$100 for each day they are uninsured up to seven days. [ss. 102.82 (2) (a) and 102.82 (2) (ag), Wis. Stat.]

In addition, an uninsured employer is personally liable for reimbursement to the Uninsured Employers Fund (Fund) for benefit payments made by the Fund under s. 102.81 (1), Wis. Stat., to an injured employee (or the employee's dependents) of the uninsured employer. [s. 102.82 (1), Wis. Stat.] The penalties and reimbursements to the Fund are mandatory and non-negotiable. The usual personal exemptions of property from seizure and sale on execution of a judgment do not apply. [s. 102.28 (5), Wis. Stat.]

Worker's Compensation Costs

The cost of worker's compensation insurance will vary. The cost does not depend on how hazardous the job is but rather on how many Wisconsin losses have occurred in the class of business of the employer. It is the business of the farmer that is classified and not the specific job.

There are several different kinds of jobs involved in farming, some of which are more hazardous than others. Nonetheless, all of these jobs are being performed for an employer engaged in farming, and all of the employees' payrolls would be classified in the same classification.

The Bureau sets the premium [rate](#) for each class with the approval of the Commissioner of Insurance. If you feel your business is not properly classified or the premium charge is not proper, you can appeal to the Bureau for review of your situation. If you are still not satisfied with the Bureau's decision, you may request, in writing, the Commissioner of Insurance hold a hearing to review the Bureau's decision.

Classification System for Farm Operations

The purpose of the worker's compensation classification system is to group similar employers so each classification reflects exposures common to them. Each classification combines the payroll and losses of similar employers to develop a price.

Most of Wisconsin farming classifications fall within the 0006 and 0008 codes in the Wisconsin Compensation Rating Bureau. Code 0006 is applicable to the typical beef and dairy cattle farm operation and includes raising cash crops like wheat and corn. Code 0008 specifies vegetable farmers who sell their products to canneries or road side stands. There is a rate per \$100 annual payroll dollars and a minimum premium payment for that classification. The rate per \$100 of payroll is only part of the premium calculation; an expense constant is added to the answer before it is compared to the minimum premium.

Once a farmer's standard premium is calculated the larger farmer's premium may be further adjusted by an experience rating factor that compares the farmer's past losses over a three-year period with losses an individual farmer of that size was expected to have during the same three-year period. If the farmer's actual losses were less than expected, credit will be given. If the farmer's actual losses were greater than expected, a surcharge will be made. Contact your insurance agent for more information on how the premium will be calculated for your individual farm operation.

Any person engaged in farming who has become subject to the Worker's Compensation Act may withdraw by filing with the Department of Workforce Development, provided he or she has not employed six or more employees on 20 or more days during the current or previous calendar year. A farmer may again become subject to this Act by employing

six or more employees on 20 different days during a calendar year. [Election of Coverage by Farmer Withdrawal - s. 102.05 (3), Wis. Stat.]

For more information on the Wisconsin Worker's Compensation Insurance Pool or if you have a complaint involving classification or rates, contact information is available on [pages 19-20](#).

Frequently Asked Questions

Who is a farmer?

The statutory definitions of farming, farm premises, farm operations, and farmers are extremely broad. The law has a long list of farm operations related to plant and animal commodities which cover everything from cultivating, breeding, tending, raising, training, managing, and harvesting to processing, drying, packing, packaging, freezing, grading, storing, delivering, distributing, or marketing. The law also says farming shall also include "any other activities commonly considered to be farming whether conducted on or off (farm) premises."

What if I rent?

It makes no difference whether the farmer owns or rents the farm premises. The same broad exemptions from the requirement to obtain insurance apply.

What if I do not make a profit?

It does not matter. There is no requirement the farmer actually succeed in raising any crop, animal, animal product, or commodity.

What about logging?

"Logging, lumbering, or wood cutting" operations are not, by themselves, considered farm operations. However, if they are done as part of other farm operations, they are considered farm operations for all worker's compensation purposes. On the other hand, clearing farm premises, salvaging dead timber, and managing and using wood lots are, by themselves, considered farming. They are not considered "logging, lumbering, or wood cutting."

What about people who provide services to farmers?

Commercial threshers, clover hullers, silo fillers, corn shredders, and other employers who work for farmers are not considered to be engaged in farming operations. These contractors become subject to the Worker's Compensation Act like any other non-farm employer. These employers and their employees are not counted for purposes of determining whether a farmer has six employees.

I recently was required to get a worker's compensation policy for my farm operation. Can I exclude my relatives from coverage under the policy?

No, relatives cannot be excluded from coverage if you own a farm corporation where all shareholders are not related. The policy covers all employees including your relatives. Insurance premiums will be charged on all of your employees' wages including any relatives who work for you. Only two corporate officers of a closely held corporation and members of a qualified religious sect who are certified for exemption by the Department of Workforce Development may be excluded from coverage. All other employees are covered. (Contact the Worker's Compensation Division to request the religious sect exemption forms and related informational materials.)

Can a farmer voluntarily obtain worker's compensation insurance?

Yes, all employers, including farmers, may voluntarily elect coverage for themselves or their employees. In the event of a work injury, they are eligible for all medical, wage, and other worker's compensation benefits, without regard to who was at fault in causing the injury. The voluntary purchase of a worker's compensation policy also protects the employer from most civil tort actions by employees related to the work injury. With few exceptions, where the employer has the worker's compensation insurance coverage in place, an injured worker is limited to the benefits to which he or she is legally entitled under the Worker's Compensation Act.

I thought I was subject to the Act, so I took out a policy. Now, I find out I was never required to have coverage.

What can I do?

Whenever anyone voluntarily elects coverage, whether purposely or by mistake—and assuming during the period for which voluntary coverage is obtained the farmer does not otherwise become subject to the Act by having six or more employees on 20 days during a calendar year—the person may cancel the policy at any time. There is no waiting period.

My neighbor and I are farmers who, together with our crews, often work together on an exchange basis on each other's farms. Do I count my neighbor's employees as my employees when they are working on my farm?

A special law applies to farmers who exchange workers. For purposes of counting, your neighbor and his or her employees are not counted toward your six-employee threshold. Your neighbor's employees are counted only by your neighbor to determine whether he or she has six employees on 20 days and is subject to the Act.

Once a farmer is required to get insurance, how long does he or she have to keep it?

Quite a while. Even if he or she permanently drops below six employees, the farmer must maintain the insurance for the remainder of that calendar year and for the next calendar year before he or she is eligible to withdraw.

Once a farmer has gone a full calendar year without employing six or more employees on 20 days, the farmer may drop insurance coverage by first filing a notice of withdrawal with the Worker's Compensation Division and then waiting 30 days. The coverage will automatically lapse. If, for some reason, the farmer wants to drop coverage more than 30 days later, the later date should be specified in the notice of withdrawal. Farmers should contact the Worker's Compensation Division for the necessary withdrawal forms.

Farmers who are not subject to the law and do not carry worker's compensation insurance may be sued in a civil action for damages by an employee who is injured while at work.

Insurance Coverage for Farm Accidents

Worker's compensation is highly recommended even for farmers who are not required to provide it by law. If you do not have worker's compensation for all family members who help with farm work, it is important to understand the insurance policy coverage for on-farm injuries and farm-related illnesses. You CANNOT assume your health insurance will cover all farm accidents. Most health insurance policies exclude "treatment, services and supplies for any injury or illness covered by worker's compensation." Some policies may also exclude treatment for any person who is ELIGIBLE FOR OR COVERED BY worker's compensation. This includes any award or settlement you may receive for any disease or injury eligible for coverage. It also means your health insurer may not cover an injury or disease that would be covered under worker's compensation.

Ask questions and get written statements about coverage for all family members who may be helping with farm work. Although farm plans marketed only to farm families are more likely to cover farm-related illness or injuries, it is important to read the exclusions and clarify benefits if you do not have worker's compensation.

Important Note: It is extremely important to read a health insurance policy very carefully when "shopping around" for insurance in order to avoid these exclusions when worker's compensation is not purchased in addition to the health insurance policy.

Insurance Marketing

For the most part, insurance is sold directly through a company or through an agent. Companies selling directly to consumers maintain their own staff of agents or sell policies through the mail. [Independent agents](#) are not employed by any insurance company and usually represent several different companies.

When you first talk to an agent, be sure he or she is willing and able to explain various policies and other insurance-related matters. An agent should look for ways to get you the most protection at an affordable cost. Make certain your agent agrees to review your coverage from time to time, advises you about other financial services, and assists you when problems develop.

Many people are interested in selling package products or services to as many people as possible. While there is nothing wrong with low cost, standardized products, they should fit your needs. If you are not convinced a particular agent understands your needs and will give you the service you want, seek another agent.

Agents and companies differ. Check with friends and relatives for recommendations. All companies and agents doing business in Wisconsin are licensed by OCI. Licensing information about agents and companies can be found on OCI's website at oci.wi.gov or by calling 1-800-236-8517.

General Anti-Discrimination Laws

There are statutes and rules protecting consumers from unfair discrimination in insurance policies. Insurers may not refuse to insure you or refuse to renew your policy on the basis of sex.

For auto or homeowner's policies, insurers may not refuse coverage to a class of risks solely on the basis of past criminal record, physical disability, past mental disability, age, marital status, sexual preference, "moral" character, or the location or age of the risk. Insurers may not use these classifications to charge different rates without credible supporting information.

No insurer may cancel or refuse to issue or renew an automobile insurance policy wholly or partially because of one or more of the following characteristics of any person: age, sex, residence, race, color, creed, religion, national origin, ancestry, marital status, or occupation. Some of the classifications may be used by an insurer if its experience supports differences in losses from these classifications.

For Your Protection

Information is available to consumers from a number of sources. These sources include public libraries, state insurance departments, consumer groups, and consumer publications. Financial strength and being able to meet financial obligations to policyholders is very important.

Independent organizations such as A.M. Best, Standard & Poors, Moody's Investors Service, and others publish financial ratings. These organizations do not rate the quality of the company's policies, practices, agents, or service. You should consider checking with at least two organizations to evaluate a company's strength. If you want to check on an insurance company's financial stability, check the reference section of your public library for published ratings, call OCI, or check with your agent.

Every state has a safety net to protect insurance consumers from financial loss in the rare instance a company becomes insolvent. This safety net is called a "guaranty fund." The guaranty funds are established by state law and are composed of licensed companies in the state. They pay the claims of policyholders and other claimants of an insolvent company.

The money to pay the claims against the insurance company comes from assessments made against all of the insurance companies that are members of the guaranty fund.

In Wisconsin, this fund is called the Wisconsin Insurance Security Fund (Fund). The Fund is created by state law and is funded by assessments of insurers licensed to do business in Wisconsin. The Fund protects residents for most claims of licensed insurers in liquidation. The Fund should not be relied upon to eliminate all risks of loss to insureds due to insurer insolvency. Some types of policies may not be fully covered and significant delays could occur in settling obligations in cases of liquidation.

Questions about the coverage and limitations of the Fund can be addressed to:

Wisconsin Insurance Security Fund
2820 Walton Commons West, Suite 135
Madison, WI 53718-6797
(608) 242-9473
wilifega.org

Where to Go for Help

OCI does not have the authority to force a company to insure anyone. However, OCI can take action against agents or insurers who misrepresent coverage, unfairly discriminate, or violate other insurance laws.

If you are having a problem with your insurance, you should first check with your agent or with the company that sold you the policy. If you do not get satisfactory answers from the agent or company, contact OCI. An online complaint form is available on OCI's website at oci.wi.gov/complaints. Make sure you have included detailed information about your insurance problem. The more complete and accurate this information is, the more likely your problem can be resolved. Be sure you have included the correct name of the insurance company from which you bought the policy. Many companies have very similar names. Listing the wrong name may delay the investigation of your complaint.

OCI investigates complaints to determine if any insurance laws have been violated. If so, OCI may take action against the agent or company involved. These actions include imposing fines or suspending or revoking licenses.

Worker's Compensation Division of the Department of Workforce Development (DWD)

Madison Area Office:
201 East Washington Ave., Room C100
P.O. Box 7901,
Madison, WI 53707-7901
(608) 266-1340 Phone
(608) 267-0394 Fax

Office Hours:
7:45 a.m. to 4:30 p.m.
Monday through Friday
Website: dwd.wisconsin.gov/wc

Contact DWD for:

- All questions relating to the Wisconsin Worker's Compensation Act
- All injury/claim questions and disputes
- Compliance questions
- Corporate officer options questions
- Employer's improper actions
- Enforcement questions
- Penalty and penalty payment plan questions
- Provider disputes
- Self-insurance questions
- Divided insurance questions
- Wrap-up policy questions
- Withdrawal questions

Wisconsin Compensation Rating Bureau (WCRB)

20700 Swenson Dr., Suite 100
P. O. Box 3080
Milwaukee, WI 53201-3080
(262) 796-4540 (Phone)
(262) 796-4400 (Fax)
Website: wcrb.org

Contact WCRB for:

- Wisconsin Worker's Compensation Insurance Pool questions
- Rate questions
- Inspection questions
- Audit questions
- Premium charging questions
- Classification questions
- Experience modification questions
- All questions regarding the proper filing of policies and endorsements pertaining to Wisconsin coverage
- Insurance company filing questions
- Endorsement filing questions
- Questions regarding appeal rights of a WCRB decision
- Questions about statistical reporting

Office of the Commissioner of Insurance (OCI)

125 South Webster Street
P. O. Box 7873
Madison, WI 53707-7873
1-800-236-8517 (Phone)
(608) 264-8115 (Fax)
Website: oci.wi.gov

Contact OCI for:

- All questions relating to the insurance laws
- Questions related to the licensing and regulation of insurance companies
- Unfair claim settlement practices questions
- Unfair marketing practices questions
- Worker's compensation rate regulation questions
- Worker's compensation dividend plans questions
- Questions related to the licensing and regulation of WCRB

Department of Agriculture, Trade and Consumer Protection (DATCP)

These resources at the Department of Agriculture, Trade and Consumer Protection (DATCP) can help farmers with or without insurance obtain free, confidential mental health support through the Wisconsin Farm Center's Farmer Wellness Program.

Wisconsin Farm Center:

datcp.wi.gov/Pages/Growing_WI/FarmCenterOverview.aspx

1-800-942-2474

Farmer Wellness Program:

datcp.wi.gov/Pages/Growing_WI/FarmerMentalHealthWellness.aspx

1-888-901-2558

Health Care Coverage Worksheet

This chart may be used to compare policies. This comparison is not intended to be a complete analysis of the plan's benefits. The policy or certificate of coverage provides a detailed description of the policy benefits. Please check your own policy for variations and further details.

Plan Name				
Premium	Monthly Annual			
Annual Deductible	Single Family			
Deductible for Specific Services	Single Family			
Coinsurance Percentage				
Copayments				
Annual Out-of-Pocket Limit				
What is not Included in the Out-Of-Pocket Limit?				
Provider Network				
Preventive Care				
• Preventive Services Subject to Cost-sharing				
• Colonoscopy Cost-sharing if Diagnostic				
Hospital Services*				
• Inpatient Services				
• Outpatient Services				
Emergency Services				
• Emergency Room Care (including Physician Charges and Misc. Expenses)				
• Ambulance Services				
Professional Services**				
• Primary Care Office Visits				
• Specialist Office Visits				
• Maternity Services				

* Some services may require precertification or prior approval. Financial penalties could apply if an approved precertification or prior approval is not in place for services received.

** The exclusions section of the policy or certificate lists the services, treatments, equipment, or supplies excluded (meaning no benefits are payable under the plan benefits) or have some

limitations on the benefit provided. Some listed exclusions may be medically necessary but still are not covered under the plan, while others may be examples of services which are not medically necessary or not medical in nature, as determined by the plan.

Professional Services** (continued)				
• Medical Supplies and Durable Medical Equipment				
• Occupational, Physical, and Speech Therapy				
• Anesthesiologist, Pathologist, and Radiologist Services				
• X-Ray and Lab Services				
Home Health Care**				
Skilled Nursing Care**				
Health Care Services**				
• Breast Reconstruction (following a covered mastectomy)				
• Diabetic Equipment, Supplies, and Self-Management				
• Smoking Cessation Programs				
• Temporomandibular Joint (TMJ) Disorders				
• Treatment for Autism Spectrum Disorders				
Transplants (prior approval may be required)**				
Alcoholism, Drug Abuse, and Nervous or Mental Disorders				
• Inpatient				
• Outpatient				
• Transitional				
Prescription Drug Coverage				
• Generic Drugs				
• Preferred Brand Drugs				
• Non-Preferred Brand Drugs				
• Specialty Drugs				
Additional Benefits				
• Adult Dental Care				
• Adult Vision Exams				
• Hearing Exams				

** The exclusions section of the policy or certificate lists the services, treatments, equipment, or supplies excluded (meaning no benefits are payable under the plan benefits) or have some limitations on the benefit provided. Some listed exclusions may be medically necessary but still are not covered under the plan, while others may be examples of services which are not medically necessary or not medical in nature, as determined by the plan.

Additional Benefits (continued)				
• Employee Wellness Program				
• Other				
Exclusions**				
• Bariatric Procedures				
• Fertility Treatment and Services				
• Other				

** The exclusions section of the policy or certificate lists the services, treatments, equipment, or supplies excluded (meaning no benefits are payable under the plan benefits) or have some limitations on the benefit provided. Some listed exclusions may be medically necessary but still are not covered under the plan, while others may be examples of services which are not medically necessary or not medical in nature, as determined by the plan.