(2) SCOPE. This rule applies to any individual accident and sickness insurance coverage which relates its benefits to Medicare, is designed to complement Medicare or is advertised or marketed as a supplement to Medicare, including hospital confinement indemnity coverage, nursing home coverage and specified disease coverage sold to the Medicare eligible, except that this rule shall not apply to conversion contracts issued as extensions or replacements for prior individual or group coverage.

(3) DEFINITIONS. For the purpose of this rule:

(a) *Medicare* means the hospital (part A) and medical (part B) insurance program established by title XVIII of the federal social security act of 1965, as amended.

(b) *Medicare eligible persons* include all persons who qualify for Medicare.

(c) *Medicare eligible expenses* are health care expenses of the type covered by Medicare, which may or may not be fully reimbursed by Medicare.

(d) *Medicare supplement coverage* means hospital, surgical or medical expense incurred and/or indemnity coverage which relates its coverage to eligibility for Medicare and which is designed to pay a specific deductible or co-payment requirement imposed under Medicare Parts A and/or B and which conforms to subsection (5) of this rule.

(e) *Hospital confinement indemnity coverage* means coverage as defined in Wisconsin Administrative Code section Ins 3.27 (4) (b) 6.

(f) *Specified disease coverage* means coverage which is limited to named or defined sickness conditions. Such coverage does not include dental or vision care coverage.

(g) *Nursing facility* means an institution which provides professional convalescent or rehabilitative services and which is licensed by the State of Wisconsin.

(h) *Outline of coverage* means an appropriately captioned or titled printed statement which meets the requirements of Wis. Adm. Code section Ins 3.27 (5) (l) and of subsection (4) (b) of this rule.

(i) Terms such as "skilled nursing facility" and "benefit period" used in this rule shall be as defined by Medicare. Terms used in Medicare supplement policies shall be worded no less favorably to the insured person than the corresponding Medicare definition.

(4) REQUIREMENTS. No accident and sickness insurance policy comprehended by this rule shall relate its coverage to Medicare or be structured, advertised or marketed as a supplement to Medicare unless:

(a) The policy:

1. Provides at a minimum the coverage set out in subsection (5);

2. Contains no pre-existing condition waiting period longer than 12 months except that a condition may be excluded from coverage by name or specific, non-generic description, effective on the date expenses are incurred; and

3. Contains in close conjunction on its first page the Designation, printed in capitals in a clear, contrasting ink in 18-point type of a style in

general use, and the Caption, printed in a clear, contrasting ink in 12-point type of a style in general use, prescribed in subsection (5); and

4. Is plainly printed as to text in black or blue ink in type of a style in general use, the size of which is uniform and not less than 10-point with a lower-case unspaced alphabet length not less than 120-point.

(b) The outline of coverage for the policy:

1. Contains a clearly worded and organized chart or charts:

a. Summarizing the benefits provided by Medicare parts A and B;

b. Summarizing the Medicare supplement benefits provided by the policy; and

c. Indicating what Medicare eligible expenses remain uncovered by Medicare and the policy;

2. Complies with sections Ins 3.27 (5) (l) and Ins 3.27 (9) (u), (v) and (zh) 2 and 4;

3. Contains conspicuous statements:

a. That Medicare will not pay for charges it deems "unreasonable and unnecessary";

b. Unless the policy explicitly provides otherwise, that the policy will not pay for charges deemed "unreasonable and unnecessary" by Medicare;

c. Unless the policy explicitly provides otherwise, that the policy will not cover expenses outside of Medicare such as routine doctor examinations or eye glasses;

d. That the chart summarizing Medicare benefits only briefly describes the program; and

e. That the federal social security administration or its Medicare publications should be consulted for further details and limitations;

4. Contains in a close conjunction on its first page the Designation, printed in capitals in a clear, contrasting ink in 24-point type of a style in general use, and the Caption, printed in a clear, contrasting ink in 18-point type of a style in general use, prescribed in subsection (5); and

5. Is submitted to the commissioner for approval along with the policy form.

(5) AUTHORIZED DESIGNATIONS AND CAPTIONS AND MINIMUM COVERAGES. For a policy to meet the requirements of subsection (4), it must contain the authorized Designation, Caption and Minimum Coverage prescribed for one of the following categories of Medicare Supplement insurance.

(a) A MEDICARE SUPPLEMENT 1 policy must include:

1. The following Designation: MEDICARE SUPPLEMENT 1

2. The following Caption: The State Insurance Commissioner's Office has established 4 categories of Medicare Supplement insurance and minimum benefit standards for each. These categories range from the most comprehensive (Medicare Supplement 1) to the least comprehensive (Medicare Supplement 4). For an explanation of the differences between this "1" policy and policies in the other categories, consult the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" which you received with the application for this policy. Do not buy this policy if you did not get this pamphlet and were not given a chance to review the Outline of Coverage provided you.

3. The following Minimum Coverage: This level of coverage shall at a minimum cover all Medicare eligible expenses listed below to at least a stated maximum of $22,500 per benefit period (inclusive of Medicare Parts A and B) or $15,000 per benefit period for Medicare Part A and $7,500 per calendar year for Medicare Part B. Benefits shall be provided for the enumerated expenses up to the stated maximum beyond the day limitations established by Medicare.

a. The following Medicare Part A eligible expenses:

1. Hospitalization, including 60 lifetime reserve days

2. Extended Care Services in a Skilled Nursing Facility

3. Home Health Care (post-hospital)

4. Blood

b. The following Medicare Part B eligible expenses:

1. Physician's services (except for routine physical examinations)

2. Home Health Care

3. Outpatient Hospital Services

i. Services in an emergency room or outpatient clinic

ii. Laboratory tests billed by a hospital

iii. X-rays and other radiology services billed by a hospital

iv. Medical supplies such as splints and casts

v. Drugs and biologicals which cannot be self-administered

4. Outpatient Physical Therapy and Speech Pathology Services

5. Other Health Services and Supplies

i. Diagnostic x-rays and independent laboratory tests

ii. Ambulance

iii. Surgical dressings

iv. Prosthetic devices

v. Durable medical equipment

vi. Portable diagnostic x-ray services

6. Blood

c. Coverage shall be provided for at least 75% of prescription drug expenses and 50% of psychiatric treatment up to a separate lifetime maximum of at least $1,000.

(b) A MEDICARE SUPPLEMENT 2 policy must include:

1. The following Designation: MEDICARE SUPPLEMENT 2

2. The following Caption: The State Insurance Commissioner's Office has established four categories of Medicare Supplement insurance and minimum benefit standards for each. These categories range from the most comprehensive (Medicare Supplement 1) to the least comprehensive (Medicare Supplement 4). For an explanation of the differences between this "2" policy and policies in the other categories, consult the Commissioner's pamphlet "Health Insurance Advice for Senior Citizens" which you received with the application for this policy. Do not buy this policy if you did not get this pamphlet and were not given a chance to review the Outline of Coverage provided you.

3. The following Minimum Coverage: This level of coverage shall at a minimum cover all Medicare eligible expenses listed below to at least a stated maximum of $15,000 per benefit period (inclusive of Medicare Parts A and B) or $10,000 per benefit period for Medicare Part A and $5,000 per calendar year for Medicare Part B. Benefits shall be provided for the enumerated expenses up to the stated maximum beyond the day limitations established by Medicare unless a minimum period is specified below.

a. The following Medicare Part A eligible expenses:

1. Hospitalization, including 60 lifetime reserve days

2. Extended Care Services in a Skilled Nursing Facility to the 100th day of confinement

3. Home Health Care (post-hospital)

b. The following Medicare Part B eligible expenses:

1. Physician's services (except for routine physical examinations)

2. Home Health Care

3. Outpatient Hospital Services

i. Services in an emergency room or outpatient clinic

ii. Laboratory tests billed by a hospital

iii. X-rays and other radiology services billed by a hospital

iv. Medical supplies such as splints and casts

v. Drugs and biologicals which cannot be self-administered

4. Outpatient Physical Therapy and Speech Pathology Services

5. Other Health Services and Supplies

i. Diagnostic x-rays and independent laboratory tests

ii. Ambulance

iii. Surgical dressings

(c) A MEDICARE SUPPLEMENT 3 policy must include:

1. The following Designation: MEDICARE SUPPLEMENT 3

2. The following Caption: The State Insurance Commissioner's Office has established four categories of Medicare Supplement insurance and minimum benefit standards for each. These categories range from the most comprehensive (Medicare Supplement 1) to the least comprehensive (Medicare Supplement 4). For an explanation of the differences between this "3" policy and policies in the other categories, consult the Commissioner's pamphlet "Health Insurance Advice for Senior Citizens" which you received with the application for this policy. Do not buy this policy if you did not get this pamphlet and were not given a chance to review the Outline of Coverage provided you.

3. The following Minimum Coverage: This level of coverage shall at a minimum cover all Medicare eligible expenses listed below to at least a stated maximum of $6,500 per benefit period (inclusive of Medicare Parts A and B) or $5,000 per benefit period for Medicare Part A and $1,500 per calendar year for Medicare Part B. Benefits shall be provided for the enumerated expenses up to the stated maximum beyond the day limitations established by Medicare unless a minimum period is specified below.

a. The following Medicare Part A eligible expenses:

1. Hospitalization to the 90th day of confinement

2. Co-payment for each of 30 lifetime reserve days of hospital confinement

3. Extended Care Services in a Skilled Nursing Facility to the 100th day of confinement

b. The following Medicare Part B eligible expenses:

1. Physician's services (except for routine physical examinations)

2. Outpatient Hospital Services

i. Services in an emergency room or outpatient clinic

ii. Laboratory tests billed by a hospital

iii. X-rays and other radiology services billed by a hospital

iv. Medical supplies such as splints and casts

3. Ambulance

(d) A MEDICARE SUPPLEMENT 4-A policy must include:

1. The following Designation: MEDICARE SUPPLEMENT 4-A - LIMITED MEDICARE PART A SUPPLEMENT ONLY.

2. The following Caption: This policy provides substantial coverage for hospitalization and other Medicare Part A expenses only. It will not pay for doctor's bills or any other Medicare Part B expenses. The State Insurance Commissioner's Office has established four categories of Medicare Supplement insurance and minimum benefit standards

for each. These categories range from the most comprehensive (Medicare Supplement 1) to the least comprehensive (Medicare Supplement 4). For an explanation of the differences between this "4-A" policy and policies in the other categories, consult the Commissioner's pamphlet "Health Insurance Advice for Senior Citizens" which you received with the application for this policy. Do not buy this policy if you did not get this pamphlet and were not given a chance to review the Outline of Coverage provided you.

3. The following Minimum Coverage: This level of coverage shall at a minimum cover all Part A Medicare eligible expenses listed below to at least a stated maximum of $15,000 per benefit period. Benefits shall be provided for the enumerated expenses up to the stated maximum beyond the day limitations established by Medicare. This policy shall not contain any coverage to Supplement Medicare Part B.

a. The following Medicare Part A eligible expenses:

1. Hospitalization, including 60 lifetime reserve days

2. Extended Care Services in a Skilled Nursing Facility

3. Home Health Care (post-hospital)

4. Blood

(e) A MEDICARE SUPPLEMENT 4-B policy must include:

1. The following Designation: MEDICARE SUPPLEMENT 4-B - LIMITED BENEFIT PART B SUPPLEMENT ONLY.

2. The following Caption: This policy provides supplemental coverage for the doctor's bill and other medical expenses under Medicare Part B only. It will not pay for hospitalization, a nursing home stay or other Medicare Part A expenses. The State Insurance Commissioner's Office has established four categories of Medicare Supplement insurance and minimum benefit standards for each. These categories range from the most comprehensive (Medicare Supplement 1) to the least comprehensive (Medicare Supplement 4). For an explanation of the differences between this "4-B" policy and policies in the other categories, consult the Commissioner's pamphlet "Health Insurance Advice for Senior Citizens" which you received with the application for this policy. Do not buy this policy if you did not get this pamphlet and were not given a chance to review the Outline of Coverage provided you.

3. The following Minimum Coverage: This level of coverage shall at a minimum cover all Part B Medicare eligible expenses listed below to at least a stated maximum of $7,500 per calendar year. Benefits shall be provided for the enumerated expenses up to the stated maximum beyond the day limitations established by Medicare. This policy shall not contain any coverage to supplement Medicare Part A. A deductible up to $500 of Medicare eligible expenses per calendar year may be included.

a. The following Medicare Part B eligible expenses:

1. Physicians Services (except for routine physical examinations)

2. Home Health Care

3. Outpatient Hospital Services

i. Services in an emergency room or outpatient clinic

ii. Laboratory tests billed by a hospital

iii. X-rays and other radiology services billed by a hospital

iv. Medical Supplies such as splints and casts

v. Drugs and biologicals which cannot be self-administered

4. Outpatient Physical Therapy and Speech Pathology Services

5. Other Health Services and Supplies

i. Diagnostic x-rays and independent laboratory tests

ii. Ambulance

iii. Surgical dressings

iv. Prosthetic devices

v. Durable medical equipment

vi. Portable diagnostic x-ray services

6. Blood

(6) PERMISSIBLE EXCLUSIONS AND LIMITATIONS: The coverages set out in subsection (5) may:

(a) exclude expenses for which the insured is compensated by Medicare.

(b) exclude coverage for the initial deductibles for Medicare Parts A and B.

(c) include any exclusion, limitation or conditions contained in Medicare.

(d) contain an appropriate provision relating to the effect of other insurance on claims.

(e) except for a Medicare Supplement 1 policy, limit coverage of psychiatric treatment to 50% of the reasonable and necessary charges and to a lifetime benefit of $500.

(7) NURSING HOME COVERAGE. (a) Any Medicare Supplement policy comprehended with subsection (5) of this rule which supplies Skilled Nursing Facility Coverage must clearly and conspicuously state in the Outline of Coverage that the nursing home coverage provided will not cover all nursing home expenses, only Medicare eligible expenses in a Skilled Nursing Facility approved by Medicare. Unless the policy explicitly provides otherwise, the Outline of Coverage must also state clearly and conspicuously that neither Medicare nor the policy will pay for "custodial care" or rest home care.

(b) Any policy which has not been approved by the commissioner as a Medicare supplement policy and which provides coverage for confinement or care in a nursing home must apply such coverage to any nursing facility and may not exclude coverage because that nursing facility is not Medicare - certified. Such nursing facility policies shall bear the following Caption: The provisions of this policy do not relate in any way to Medicare. This policy will not cover

custodial care or rest home care. For more information, consult the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" which you received with the application for this policy.

(c) The Caption shall be placed on the front of each Outline of Coverage and on a separate half-sheet attached to the front of the policy. The Caption shall be conspicuously placed and printed in 18-point bold capital letters.

(8) HOSPITAL CONFINEMENT INDEMNITY COVERAGE. (a) Any hospital confinement indemnity coverage sold to a Medicare eligible person shall bear the following Caption: Attention Policyholder: This policy is not designed to fill the "gaps" of Medicare. It will compensate you only for a fixed dollar amount for a limited number of days you are hospital confined. For more information, consult the Commissioner's pamphlet "Health Insurance Advice for Senior Citizens" which you received with the application for this policy.

(b) The Caption shall be placed on the front of each outline of coverage and on a separate half-sheet attached to the front of the policy. The Caption shall be conspicuously placed and printed in 18-point bold capital letters.

(9) SPECIFIED DISEASE COVERAGE. (a) No policy providing benefits for specified diseases, or treatments unique to specified diseases or additional benefits for such specified diseases or treatments shall be sold to a Medicare eligible person unless it bears the following Designation: SPECIFIED OR RARE DISEASE LIMITED POLICY, followed by this Caption: Attention Policyholder: This policy is designed to cover only narrowly-defined illnesses or threats to your health which are unusual compared to the health care problems of the general public. This policy should not be purchased as a substitute for broad-based health protection which could pay you for hospital and medical expenses incurred due to any of a variety of disorders. For more information, consult the Commissioner's pamphlet "Health Insurance Advice for Senior Citizens" which you received with the application for this policy.

(b) The Caption shall be placed on the front of each outline of coverage and on a separate half-sheet attached to the front of the policy. The Caption shall be printed in 18-point bold capital letters.

(10) "HEALTH INSURANCE ADVICE FOR SENIOR CITIZENS" PAMPHLET. Every prospective Medicare eligible purchaser of any policy subject to this rule must receive a copy of the current edition of the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" at the time the prospect is provided an application. This pamphlet prepared by the Office of the Commissioner of Insurance provides information on Medicare and advice to senior citizens on the purchase of Medicare supplement insurance and other health insurance. Insurers may obtain copies of this pamphlet from the Commissioner at cost or may reproduce this pamphlet themselves. This pamphlet shall be periodically revised to reflect changes in Medicare and any other appropriate changes. Prior to the publication of the revised pamphlet, it shall be submitted to the Disability Subcommittee of the Forms and Classification Advisory Council and the Insurance Consumers Advisory Council for review. No insurer shall be responsible for providing applicants the revised pamphlet until 30 days after the

insurer has received notice that the revised pamphlet is available at the commissioner's office.

(11) APPROVAL NOT A RECOMMENDATION. While the commissioner may authorize the use of a particular Designation on a policy in accordance with this rule, that authorization is not to be construed or advertised as a recommendation of any particular policy by the commissioner or the state of Wisconsin.

(12) SEVERABILITY. If any provision of this rule or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications or the rule which can be given effect without the invalid provision or application, and to this end the parts of the rule are declared to be severable.

(13) EFFECTIVE DATE. This rule shall take effect January 1, 1978.

Note: Subsequent to the adoption of this rule but prior to its effective date the pamphlet required by subsection (10) shall be revised pursuant to the procedures of that subsection. The revised pamphlet shall include information on this rule and contain other appropriate changes.

History: Cr. Register, July, 1977, No. 259, eff. 8-1-77; am. (13), Register, September, 1977, No. 261, eff. 10-1-77.

2. Private boarding and rooming houses and tourist homes, permanent or seasonal, with not more than 20 rooms for lodging and (or) with not more than 20 boarders.

3. Nurses' and sisters' homes with not over 10 sleeping rooms.

4. Private outbuildings used in connection with any of the foregoing.

5. Trailer homes at a fixed location.

6. Household and personal property in risks described in subparagraphs 1 through 5.

7. Tenants' contents in apartment houses.

(j) *Servicing company* means an insurer which issues and services policies referred to it by the Plan.

(k) *Non-servicing company* means an insurer which does not issue policies under the Plan.

(4) ELIGIBLE RISKS. (a) All risks at a fixed location shall be eligible for inspection and insurance under this Plan except motor vehicles, farm risks, and manufacturing risks as defined in subsection (3) (e), (f), and (g).

(b) The maximum limits of coverage for the type of basic property insurance defined in subdivisions 1. and 4. of subsection (3) (c) which may be placed under this Plan are $100,000 on any habitational risk at one location and $500,000 on any other eligible property at one location. If the full insurable value at one location is in excess of applicable limits, the Plan, upon specific application, will seek to place the additional amounts of coverage.

(c) The maximum limits of coverage for the type of basic property insurance defined in subsection (3) (c) 2. which may be placed under this plan are $5,000 on any habitational risk at one location and $15,000 on any other eligible property at one location. If the full insurable value at one location is in excess of applicable limits, the Plan, upon specific application, will seek to place the additional amounts of coverage.

(5) MEMBERSHIP. (a) Every insurer, as defined in subsection (3) (b), licensed to write one or more components of basic property insurance, as defined in subsection (3) (c), shall be considered a member of this Plan. Any other insurer may, upon application to and approval by the governing committee, become a member.

(b) An insurer's membership terminates when the insurer is no longer authorized to write basic property insurance in Wisconsin, but the effective date of termination shall be the last day of the fiscal year of the Plan in which termination occurs. Any insurer so terminated shall continue to be governed by the provisions of this rule until it completes all of its obligations under the Plan.

(c) Any voluntary insurer member may terminate its membership only as of the last day of the fiscal year of the Plan by giving written notice to the Plan 30 days prior to the last day of the fiscal year of the Plan. The governing committee upon a majority vote may terminate the membership of a voluntary insurer. Any such terminated member shall continue to be governed by the provisions of this rule until it completes all of its obligations under the Plan.

(d) Subject to the approval of the commissioner, the governing committee may charge a reasonable annual membership fee.

(6) ADMINISTRATION. (a) This Plan shall be administered by a governing committee, subject to the supervision of the commissioner, and operated by a manager appointed by the governing committee.

(b) The governing committee shall consist of 9 members, each of whom shall serve for a period of one year or until a successor is elected or designated. Each shall have one vote.

1. The following associations shall appoint or elect:
American Insurance Association—one member
American Mutual Insurance Alliance—one member
National Association of Independent Insurers—one member
Wisconsin Insurance Alliance—three members

2. All other insurers not members of the associations in subparagraph 1 shall elect one member by weighted votes based on each insurer's weighted premiums written.

3. The commissioner shall appoint members to represent:
Stock agents—one member
Mutual agents—one member

4. Not more than one insurer in a group under the same management or ownership shall serve on the governing committee at the same time.

(7) DUTIES OF THE GOVERNING COMMITTEE. (a) The governing committee shall meet as often as may be required to perform the general duties of the administration of the Plan or on the call of the commissioner. Five insurers of the committee shall constitute a quorum.

(b) The governing committee shall be empowered to appoint a manager, who shall serve at the pleasure of the committee, to budget expenses, levy assessments, disburse funds, and perform all other duties provided herein as necessary or incidental to the proper administration of the Plan. The adoption of or substantive changes in pension plans or employee benefit programs shall be subject to approval of insurers.

(c) The governing committee may designate, with the approval of the commissioner, a rate service organization as defined in section 625.02 (2), Wis. Stats., to make inspections as required under this Plan and to perform such other duties as may be authorized by the governing committee.

(d) The manager shall annually prepare an operating budget which shall be subject to approval of the governing committee. Such budget shall be furnished to the insurers after approval. Any contemplated expenditure in excess of or not included in the annual budget shall require prior approval by the governing committee.

(e) The governing committee shall submit to the commissioner and to the secretary of the U.S. department of housing and urban development periodic reports setting forth the number of requests for inspection, the number of risks inspected, accepted, declined and conditionally declined, the number of reinspections made, and such other information as the commissioner or the secretary may request.

(f) The governing committee shall cause all policies written pursuant to this Plan to be separately coded so that appropriate records may be

compiled for purposes of performing loss prevention and other studies of the operation of the Plan.

(g) The governing committee shall determine, subject to the approval of the commissioner, the eligibility of an insurer to act as a servicing company. No insurer which elects to be a non-serving company shall be required to be one, but if not enough insurers elect to be servicing companies, the governing committee may authorize the manager to perform directly the duties of a servicing company.

(h) The governing committee shall prepare such agreements and contracts as may be necessary for the execution of this rule consistent with its provisions.

(8) ANNUAL AND SPECIAL MEETINGS. (a) There shall be an annual meeting of the insurers on a date fixed by the governing committee at which time members may be chosen under subsection (6) (b).

(b) A special meeting may be called at any time by the governing committee and shall be called within 40 days by the governing committee after receipt of a written request from any 10 insurers, not more than one of which may be in a group under the same management or ownership.

(c) The time and place of all meetings shall be reasonable. Twenty days' notice of such annual or special meeting shall be given in writing by the governing committee to all insurers under subsection (3) (b). A majority of the insurers present in person or by proxy shall constitute a quorum. Voting by proxy shall be permitted.

(d) Any matter not inconsistent with the law or this rule may be proposed and voted upon by mail by unanimous action of the members of the governing committee present and voting at any meeting of the committee. Notice of any such proposal shall be mailed to each insurer not less than 20 days prior to the final date fixed by the committee for voting thereon.

(e) Any vote of insurers shall be counted on a weighted basis in proportion to each insurer's weighted premiums written. A proposal shall become effective when approved by at least two-thirds of the weighted votes cast.

(9) APPLICATION FOR INSPECTION OR INSURANCE. (a) Any person having an insurable interest in an eligible risk under paragraphs (a) or (b) of subsection (4), may apply for inspection of the property or for insurance by the Plan. The application for inspection need not be in writing.

(b) With regard to property insurance defined in subsection (3) (c) 2. and 3., inspection need not be made if the governing committee determines that insurance can be provided for specified classes of risks on the basis of representations of the applicant or the insurance agent.

(c) The Plan may bind coverage.

(10) INSPECTION PROCEDURE. (a) The inspection by the Plan shall be without cost for the applicant.

(b) The manner and scope of the inspection shall be prescribed by the Plan with the approval of the commissioner.

(c) An inspection report shall be made for each property inspected covering pertinent structural and occupancy features as well as the general condition of the building and surrounding structures. Representative photographs may be taken during the inspection to indicate the pertinent features of building, construction, maintenance, occupancy, and surrounding property.

(d) During the inspection, the inspector shall point out features of structure and occupancy to the applicant or his representative and shall indicate those features which may result in additional charges for deficient physical conditions if the risk is accepted. The inspector shall have no authority to advise whether any insurer will provide the coverage.

(e) After the inspection, a copy of the completed inspection report and any relevant photographs shall be sent to the Plan within 5 business days or, if requested by the applicant, to an insurer of his choice. The report shall include a rate make-up statement, including any deficient physical condition charges proposed by the inspector. A copy of the inspection report shall be made available to the applicant or his agent upon request.

(11) PROCEDURE AFTER INSPECTION. (a) The Plan shall, within 3 business days after receipt of the inspection report and application, complete and send to the applicant an action report advising him of one of the following:

1. That the risk is acceptable. If the inspection reveals substandard conditions, appropriate charges may be imposed but the report shall specify the improvements necessary for removal of each such charge.

2. That the risk will be acceptable if reasonable improvements noted in the action report are made by the applicant and confirmed by reinspection.

3. That the risk is not acceptable because it fails to meet reasonable underwriting standards specified in the action report. Reasonable underwriting standards shall not include neighborhood or area location or any environmental hazard beyond the control of the property owner. They may include but are not limited to the following:

a. Serious defects in the physical condition of the property, such as its construction, heating, wiring; evidence of previous losses, general deterioration or lack of protective measures;

b. Serious hazards resulting from its present use or housekeeping, such as vacancy, overcrowding, storage of rubbish or flammable materials.;

c. Violation of law which results in increased exposure to loss;

d. Previous loss history or matters of public record concerning the applicant.

(b) If the risk is accepted by the Plan, the servicing company shall deliver the policy to the applicant upon payment of the premium to the servicing company. The servicing company shall remit the commissions to the licensed agent designated by the applicant; if no licensed agent is so designated, the commissions shall be remitted to the Plan.

(c) If the risk is conditionally declined under paragraph (a) 2. or declined under paragraph (a) 3. but can be improved to meet reasonable

standards the Plan shall promptly advise the applicant what improvements noted in the action report should be made to the property. Upon completion of the improvements by the applicant or property owner, the Plan, when so notified, will have the property promptly reinspected under subsection (10) and shall send a new action report to the applicant.

(d) If a risk is conditionally declined under paragraph (a) 2. or declined under paragraph (a) 3., the Plan shall, within 3 business days, send copies of the inspection and action reports to the property owner and to the commissioner and shall advise the property owner of his right to appeal and the procedure therefor.

(12) DISTRIBUTION OF PLAN INSURANCE. (a) The Plan shall equitably distribute risks under subsection (11) (a) 1 to servicing companies with consideration of the servicing company experience in servicing such risks in the areas where the risks are located.

(b) Any risk which has been accepted by the Plan and a policy issued by a servicing company may be renewed by the same servicing company and credit will be given to said servicing company against its share of servicing company assignments.

(13) ASSESSMENTS. (a) Participation and assessments by and upon each insurer in the Plan for losses and expenses in connection with Plan business shall be levied and assessed by the governing committee of the Plan on the basis of participation factors determined annually, giving effect to the proportion which such insurer's weighted premiums written bears to the aggregate weighted premiums written by all insurers in the Plan.

(b) All servicing expenses, losses, and loss adjustment expenses of a servicing company will be recoverable from the Plan upon approval of the governing committee.

(c) If any member fails to pay an assessment within 30 days after it is due, the unpaid assessment may be collected from the remaining members. The Plan may then collect the delinquent assessment on behalf of the remaining members in any liquidation proceeding or by the use of any other available remedy and shall have full authority to act in their behalf in any action or proceeding.

(14) RATES. (a) The rate and surcharge schedules shall be subject to approval by the commissioner prior to use.

(b) The rates to be charged for coverage shall be determined after an actual inspection of the premises by the Plan.

(c) The renewal rates shall be the rates in effect on the renewal date unless an inspection reveals an indicated increase or decrease in rates.

(15) VOLUNTARY BUSINESS—CANCELLATION AND NONRENEWAL. (a) Any insurer cancelling or not renewing voluntarily written basic property insurance covering any risk eligible under this Plan shall inform the policyholder of the availability of insurance under the Plan. Any such notice of cancellation or nonrenewal shall allow ample time for application to the Plan and for the issuance of coverage.

(b) No servicing company shall cancel or refuse to renew a policy issued under this Plan except for:

1. Facts as confirmed by inspection which would have been grounds for nonacceptance of the risk under the Plan had they been known to the Plan at the time of acceptance; or

2. Changes in the physical condition of the property or other changed conditions as confirmed by inspection or investigation that make the risk uninsurable under the Plan rules; or

3. Nonpayment of premiums; or

4. Conviction of the policyholder of arson or fraudulent claim.

(c) Notice of cancellation or nonrenewal under paragraph (b), containing a statement of the reasons therefor, shall be sent to the insured with a copy to the Plan. Any cancellation or nonrenewal notice to the insured shall be accompanied by a conspicuous statement that the insured has a right of appeal as provided in subsection (19).

(16) COMMISSION. (a) Commission to the licensed agent designated by the applicant shall be 10% of the policy premium. The agent need not be licensed by the servicing company.

(b) In the event of cancellation of a policy, or if an endorsement is issued which requires premium to be returned to the insured, the agent shall refund ratably to the insurer commissions on the return premium at the same rate at which such commissions were originally paid.

(17) PUBLIC EDUCATION. The Plan shall undertake a continuing public education program to assure that the Plan receives adequate public attention. All insurers and agents shall cooperate fully in the public education program.

(18) COOPERATION OF AGENTS. Each insurer shall require its licensed insurance agents to cooperate fully in the accomplishment of the intents and purposes of the Plan.

(19) RIGHT OF APPEAL. Any affected person may appeal to the governing committee within 30 days after any final ruling, action, or decision of the Plan. The governing committee must consider the appeal and render a decision promptly after receipt of any such appeal. Any decision of the governing committee may be further appealed to the commissioner within 30 days. Orders of the commissioner shall be subject to judicial review.

(20) REVIEW BY COMMISSIONER. The governing committee shall report to the commissioner the name of any insurer or agent which fails to comply with the provisions of the Plan or with any rules prescribed thereunder by the governing committee or to pay within 30 days any assessment levied.

(21) INDEMNIFICATION. Each person serving on the governing committee or any subcommittee thereof, each member of the Plan, and the manager and each officer and employee of the Plan shall be indemnified by the Plan against all cost, settlement, judgment, and expense actually and necessarily incurred by him or it in connection with the defense of any action, suit, or proceeding in which he or it is made a party by reason of his or its being or having been a member of the governing committee, or a member or manager or officer or employee of the Plan except in relation to matters as to which he or it has been judged in such action, suit, or proceeding to be liable by reason of willful misconduct in the

performance of his or its duties as a member of such governing committee, or a member or manager or officer or employee of the Plan. This indemnification shall not apply to any loss, cost or expense on insurance policy claims under the Plan. Indemnification hereunder shall not be exclusive of other rights to which the member, manager, officer, or employee may be entitled as a matter of law.

(22) TRANSITION. The voluntary Wisconsin Insurance Plan shall terminate as of January 1, 1970, and the assets and liabilities of such plan shall be assumed by the Plan established by this rule effective January 1, 1970, in accordance with the procedures established by the governing committee of the respective plans.

(23) EFFECTIVE DATE. Basic property insurance coverage as defined in subsection (3) (c) 4. must be available to acceptable risks no later than 30 days after the effective date of the amendment of that subsection.

History: Cr. Register, December, 1969, No. 168, eff. 1-1-70; am. (3) (c) and (4) (b), cr. (4) (c), am. (5) (a) and (9) (a), renum. (9) (b) to be (c), and cr. (9) (b), am. (11) (a) 3. a. and c. and cr. 3. d, am. (15) (b) 2. and 4., Register, June, 1971, No. 186, 7-1-71; am. (3) (c) 3., Register, August, 1971, No. 188, eff. 9-1-71; emerg. am. (2), (3) (c) 1, 2, and 3, eff. 6-22-76; am. (2), (3) (c) 1, 2, and 3, Register, September, 1976, No. 249, eff. 10-1-76; am. (3) (c), (4) (b) and (23), Register, April, 1977, No. 256, eff. 5-1-77; am. (3) (h) 2, Register, May, 1978, No. 269, eff. 6-1-78.

where all vehicles displayed in the showroom are without batteries and fuel tanks are empty and free of fumes.

Note: A live storage area is any area used for storage of fire trucks, tractors, automobiles, trucks, and similar self-propelled vehicles which are driven in and out of the storage area under their own power; it does not include areas where vehicles and equipment are stored for seasonal periods, or areas where vehicles are displayed without batteries and where the gasoline tanks of the vehicles are empty and free of fumes.

(2) VENTILATION. The air movement, supply and distribution shall be provided in accordance with the requirements of s. ILHR 64.05, Table 1.

(a) *Separate ventilating system.* A separate ventilating system shall be provided for showrooms or offices where such occupancies are adjacent to repair or live storage areas.

Note: Ventilation is not required if an openable area is provided to conform with the requirements of s. ILHR 64.07.

(b) *Recirculation.* Air shall not be recirculated from any repair, live storage or service area unless the total volume of air in circulation is in excess of the ventilation required. Excess air may be recirculated.

(c) *Contaminants.* If the provisions of this section do not provide sufficient ventilation to meet the standards for threshold limit values covered in chs. Ind 1000-2000—Safety and Health Code, the additional exhaust requirements with an equivalent volume of outside air shall be provided to satisfy the requirements found in chs. Ind 1000-2000.

History: Cr. Register, December, 1975, No. 240, eff. 1-1-76; am. (1), Register, December, 1983, No. 336, eff. 1-1-84.

ILHR 64.65 General sanitation and service areas. (1) SCOPE. This classification shall include toilet rooms, locker rooms, shower rooms and janitor closets.

Note #1: A janitor closet is a service closet with one or more plumbing fixtures.

Note #2: For exhaust ventilation requirements in hospital service areas, see s. ILHR 64.57.

Note #3: For exhaust ventilation requirements in places of employment, see s. ILHR 64.54.

Note #4: The use of wall registers within 4 inches of the floor, baseboard registers, and floor registers is prohibited in these areas. (See s. ILHR 52.57, Note.)

Note #5: The rules of this section are not intended to preclude the use of energy recovery wheels, plate type heat exchangers or similar energy recovery equipment.

(2) EXHAUST VENTILATING SYSTEMS. Exhaust ventilating systems serving this class of occupancy may not be combined with other exhaust services provided the combined system:

(a) Does not allow recirculation; and

(b) Does not include grease hood exhaust, radioactive exhaust, fume hood exhaust, exhaust required by chs. Ind 1000-2000, exhaust that requires electical grounding, or exhaust that requires spark resistant fan construction.

(3) VENTILATION. The air movement, supply and distribution shall be provided in accordance with the requirements of s. ILHR 64.05, Table 1.

(a) *Exhaust ventilation.* Exhaust ventilation shall be provided for all areas of this class unless otherwise exempted. The volume of air exhausted shall be provided at a rate of not less than 2 cubic feet per minute

per square foot of floor area, or 60 cubic feet per minute per fixture (water closets and urinals). Mechanical exhaust ventilation shall be installed in toilet rooms having more than one fixture (water closets and urinals). The effectiveness of the exhaust shall be greater than the supply.

(b) *Natural ventilation.* Exhaust ventilation is not required from toilet rooms having one water closet or one urinal, or from janitor closets having one service sink or receptor, provided the room has an outside window of at least 4 square feet with at least 2 square feet that is openable.

1. Exception. Mechanical exhaust ventilation may be omitted from toilet rooms or bathrooms having one water closet or urinal except in taverns and restaurants, or from janitor closets having one service sink or receptor, where an approved ductless air circulating and treatment device is provided.

(c) *Locker, shower and toilet room ventilation.* Adjoining locker, shower and toilet rooms shall be exhausted at the rate of 2 cubic feet per minute per square foot of area, based on the floor area of the largest space. The rooms shall be provided with tempered makeup air supplied directly from the outside or transferred from other areas of the building in accordance with the requirements of s. ILHR 64.18. A negative pressure relationship shall be maintained in the shower and toilet rooms with respect to the locker room.

History: Cr. Register, December, 1975, No. 240, eff. 1-1-76; am. (1), cr. (3) (c) and r. (4), Register, December, 1976, No. 252, eff. 1-1-77; cr. (3) (b) 1, Register, December, 1977, No. 264, eff. 1-1-78; am. (3) (b) 1., Register, December, 1981, No. 312, eff. 1-1-82; am. (3) (b) 1., Register, December, 1983, No. 336, eff. 1-1-84; r. and recr. (2), Register, August, 1985, No. 356, eff. 1-1-86.

ILHR 64.66 Natatoriums. (1) POOL VENTILATION. In natatoriums, a volume of tempered outside air supply and exhaust shall be provided at the rate of at least 2 cubic feet per minute per square foot of pool surface. The volume of tempered outside air and exhaust may be reduced to a minimum of one cubic foot per minute per square foot of pool surface provided humidity controls are used to limit the relative humidity to 60%.

(2) AIR MOVEMENT. The air movement in a natatorium shall be not less than 6 air changes per hour unless mechanical cooling is provided to satisfy the heat gain requirement for the space.

History: Cr. Register, December, 1976, No. 252, eff. 1-1-77.

ILHR 64.67 Kitchens (1) SCOPE. This classification includes all areas where food is prepared (except in domestic science educational facilities from grades kindergarten through 12, and single unit apartments in hotels, motels and apartment buildings).

(2) EXHAUST VENTILATION SYSTEMS. Exhaust ventilation systems serving this occupancy shall not be used for any other service.

(a) *Required exhaust ventilation.* When cooking equipment is being operated, mechanical exhaust ventilation shall be provided at a rate not less than 2 cubic feet per minute per square foot of floor area for every occupied area within the scope of this section. When cooking equipment is not being operated, a minimum supply of outside air and exhaust at the rate of 5 CFM per person or natural ventilation as specified in s. ILHR 64.07 shall be provided during periods of occupancy.