(2) SCOPE. This rule applies to any individual accident and sickness insurance coverage sold to the Medicare eligible which relates its benefits to Medicare, is designed to complement Medicare or is advertised or marketed as a supplement to Medicare, including any contracts purporting to offer comprehensive medical or surgical coverage sold predominantly to the Medicare eligible. This rule also applies to individual hospital confinement indemnity coverage, nursing home coverage and specified disease coverage sold to Medicare eligible. Except for subsection (8), this rule does not apply to conversion contracts offered as replacements for prior individual or group coverage or to individual or group coverage which continues after an insured becomes eligible for Medicare.

(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 provide coverage beyond what Medicare provides, 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) MEDICARE SUPPLEMENT POLICY 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) and applicable statutes;

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, except that the outline applicable to a Medicare Supplement 4-A policy need not summarize Medicare Part B and the outline applicable to a Medicare Supplement 4-B policy need not summarize Medicare Part A;

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 regarding Medicare;

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);

5. Complies with (7) (b) 1.; and

6. Summarizes or refers to the coverage set out in applicable statutes; and

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

(5) AUTHORIZED MEDICARE SUPPLEMENT POLICY DESIGNATIONS, 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 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 "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 inpatient psychiatric care

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. Medical supplies

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 outpatient 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.

a. The following Medicare Part A eligible expenses:

1) Hospitalization, including inpatient psychiatric care

2) Extended Care Services in a Skilled Nursing Facility

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. Medical supplies

(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 including inpatient psychiatric care

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 (not including physical therapy or speech pathology)

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 inpatient psychiatric care

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 may be included of up to $100 per calendar year for Medicare eligible expenses not paid by Medicare.

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. Medical supplies

iv. Prosthetic devices

v. Durable medical equipment

vi. Portable diagnostic x-ray services

6) Blood

(6) PERMISSIBLE MEDICARE SUPPLEMENT POLICY EXCLUSIONS AND LIMITATIONS. (a) The coverages set out in subsection (5) may:

1. Exclude expenses for which the insured is compensated by Medicare.

2. Exclude coverage for the initial deductibles for Medicare Parts A and B.

3. Include any exclusion or condition contained in Medicare, except that inhospital treatment of mental illness shall be covered the same as any other illness.

4. Contain an appropriate provision relating to the effect of other insurance on claims.

5. Except for a Medicare Supplement 1 policy for which a specific requirement is set out in subsection (5) (a) 3. c., limit coverage of outpatient psychiatric treatment to 50% of the reasonable and necessary charges and to a lifetime benefit of $500.

6. Contain a pre-existing condition waiting period provision as provided in subsection (4) (a) 2.

(b) Where the insured chooses not to enroll in Medicare Part B, the insurer may exclude from coverage the expenses which Medicare Part B would cover. Medicare Part B expenses incurred beyond what Medicare Part B would cover may not be excluded.

(7) NURSING HOME, HOSPITAL CONFINEMENT INDEMNITY AND SPECIFIED DISEASE COVERAGES. (a) Captions for the policies listed in this subsection shall be:

1. Printed and conspicuously placed on the first page of the Outline of Coverage,

2. Printed on a separate form attached to the first page of the policy, and

3. Printed in 18-point bold capital letters.

(b) Nursing Home Coverage.

1. The Outline of Coverage for a policy subject to subsection (5) which provides Skilled Nursing Facility Coverage shall contain clear and conspicuous statements that:

a. The nursing home coverage will not cover all nursing home expenses,

b. Only eligible nursing home expenses as defined in the policy will be covered.

c. Medicare pays no benefits for custodial care or rest home care, and

d. The policy, unless it provides otherwise, pays no benefits for custodial or rest home care.

2. A policy form which has not been approved by the commissioner under subsection (5) and which provides coverage for confinement or care in a nursing home shall provide such coverage for confinement in any nursing facility and may not exclude coverage because a nursing facility is not Medicare-certified. Such a policy sold to Medicare eligible persons shall bear the following Caption: THE NURSING HOME BENEFIT OF THIS POLICY DOES NOT RELATE IN ANY WAY TO MEDICARE. IT 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.

3. A policy which covers nursing home custodial care or rest home care may be described in the Caption as covering such care, if such Caption is accurately and reasonably worded to indicate, for example, that the policy provides limited custodial care or rest home care.

(c) Hospital Confinement Indemnity Coverage. A policy form providing hospital confinement indemnity coverage sold to a Medicare eligible person shall bear the following Caption: THE HOSPITAL CONFINEMENT INDEMNITY BENEFIT OF THIS POLICY IS NOT DESIGNED TO FILL THE GAPS IN MEDICARE. IT WILL PAY YOU ONLY A STATED DOLLAR AMOUNT FOR A DESIGNATED NUMBER OF DAYS WHEN 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.

(d) Specified Disease Coverage. A policy form providing benefits only for one or more specified diseases sold to a Medicare eligible person shall bear:

1. The following Designation: SPECIFIED OR RARE DISEASE LIMITED POLICY, and

2. The following Caption: THIS POLICY IS DESIGNED TO COVER ONLY ONE OR MORE SPECIFIED OR RARE ILLNESSES. IT SHOULD NOT BE PURCHASED AS A SUBSTITUTE FOR HEALTH CARE EXPENSE COVERAGE WHICH WOULD GENERALLY COVER ANY ILLNESS OR INJURY. FOR MORE INFORMATION, CONSULT THE COMMISSIONER'S PAMPHLET "HEALTH INSURANCE ADVICE FOR SENIOR CITIZENS" WHICH YOU RECEIVED WITH THE APPLICATION FOR THIS POLICY.

(8) CONVERSION OR CONTINUATION OF COVERAGE. (a) An Outline of Coverage as described in par. (e) and a copy of the current edition of the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" shall be furnished by an insurer upon request to each insured who will become eligible for Medicare and is offered a conversion policy under the terms of a group insurance policy.

(b) An insurer:

1. Which provides group insurance coverage shall furnish annually to each group policyholder written notice of the availability of the information described in pars. (a) or (d), where applicable, and upon request shall furnish sufficient copies of the same or similar notice to the group policyholder to be distributed to group members affected; and

2. Which provides individual or family insurance coverage shall furnish an Outline of Coverage as described in par. (e) and a copy of the current edition of the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" at the time an insured who will become eligible for Medicare is furnished an application for conversion.

(c) Except as provided under par. (d), an insurer shall furnish an Outline of Coverage and a copy of the current edition of the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" within 14 calendar days after receipt of the request for such information.

(d) Upon request, a comprehensive written explanation of the insurance coverage to be provided after Medicare eligibility and a copy of the current edition of the commissioner's pamphlet "Health Insurance Advice for Senior Citizens" shall be furnished by the insurer within 14 calendar days after receipt of the request to each insured who will become eligible for Medicare whose coverage under an individual, family or group insurance policy will continue with changed benefits (e.g. "carve-out" or reduced benefits).

(e) The Outline of Coverage:

1. For a conversion policy which relates its benefits to or complements Medicare shall comply with subsection (4) (b) 1., 2., 3., and 6. of this rule and shall be submitted to the commissioner; and

2. For a conversion policy not subject to subd. 1. shall comply with subsection (7), where applicable, and section Ins 3.27 (5) (1).

(9) "HEALTH INSURANCE ADVICE FOR SENIOR CITIZENS" PAMPHLET. Every prospective Medicare eligible purchaser of any policy subject to this rule or coverage added to an existing Medicare Supplement policy 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 contacted by an intermediary or insurer with an invitation to apply as defined in Ins 3.27 (5) (g). 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.

(10) 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.

(11) 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 of 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.

(12) 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 (9) shall be revised pursuant to the procedures of that subsection. The revised pamphlet shall include information on this rule and contain other appropriate changes.

Note: Insurers may use current supplies of forms which comply with subsections (7), (8) and (9) of the original rule which became effective January 1, 1978, until those supplies are exhausted, but all forms subject to newly created subsection (7) shall comply with this rule as amended by July 1, 1979.

History: Cr. Register, July, 1977, No. 259, eff. 8-1-77; am. (13), Register, September, 1977, No. 261, eff. 10-1-77; am. (2), (3) (d), (4) (a) 1., (4) (b) 1. a., 3. e. and 4., (5) (a) 3. a., (5) (b) 3. intro., 3. a., 3. b., (5) (c) 3. a. and b., (5) (d) 3. a., (5) (e) 3. intro. and a., r. and recr. (4) (b) 5., (6), (7), (8) and (9), r. (10), renum. (11) to (13) to be (10) to (12), cr. (4) (b) 6. and 7., Register, December, 1978, No. 276, eff. 1-1-79.

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 14 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
Alliance of American Insurers—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
Consumers and other persons not affiliated in any way with the insurance industry—five members

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. Nominees for individuals to serve as consumer members and as representatives of other persons not affiliated in any way with the insurance industry shall be sought from community groups, local agencies, and from other members of the governing committee.

(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. The changes in the composition of the governing committee authorized by subsection (6) shall become effective January 1, 1979.

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; am. (6) and (23), Register, December, 1978, No. 276, eff. 1-1-79.