CODE OF MASSACHUSETTS REGULATIONS
TITLE 211: DIVISION OF INSURANCE
CHAPTER 146.00: SPECIFIED DISEASE INSURANCE

Section

146.01: Purpose

The purpose of 211 CMR 146.00 is to provide for full and fair disclosure of the provisions of specified disease insurance policies offered for sale in Massachusetts and to promote the public interest by protecting applicants for specified disease insurance from unfair or deceptive sales and enrollment practices. 211 CMR 146.00 et seq. establishes minimum benefit levels for individual policies and minimum standards for disclosure, marketing and agent training for both individual specified disease policies and group specified disease policies that are not employment-based. 211 CMR 146.00 also restricts or prohibits provisions which may be misleading, confusing or contrary to the needs of the public, and prohibits coverages that are so limited in scope as to be of no substantial economic value to the insured.

146.02: Applicability

211 CMR 146.00 applies to specified disease insurance policies offered in Massachusetts after January 1, 2003. The requirements contained in 211 CMR 146.00 are in addition to any other applicable statutory provisions or lawful regulations.

146.03: Authority

211 CMR 146.00 is issued under the authority of M.G.L. c. 175, § 108, c. 176, 176M and c. 176D, § 11.

146.04: Definitions

Agent means an insurance producer licensed under M.G.L. c. 175, § 162I or an agent of a fraternal benefit society licensed in accordance with M.G.L. c. 176, § 35.

Carrier means a commercial insurance company licensed to issue accident and sickness policies under M.G.L. c. 175 or a fraternal benefit society licensed under M.G.L. c. 176.

Cold-lead Advertising means making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that one of the purposes of the method of marketing is the solicitation of insurance and that contact will be made by a carrier or its agent.

Commissioner means the commissioner of insurance or his/her designee.

Disease means a medical condition as identified in the most recent edition of the International Classification of Diseases or succeeding document.

Employment-based Group Policy means a certificate issued to an insured who is enrolled in a group policy issued to one or more employers or labor organizations, or to the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

Group Policy means the certificate issued to an insured who is enrolled through a group trust or association to which the carrier has issued a specified disease insurance policy. For the purposes of 211 CMR 146.00, this does not include an employment-based group policy.

Guaranteed Renewable means a policy feature that guarantees the insured's right to continue the policy in force by the timely payment of premiums. A carrier cannot cancel, cannot decline to renew, and cannot make any unilateral change in any provision of a guaranteed renewable policy without the agreement of the insured, but subject to the approval of the commissioner, a carrier may revise premium rates for guaranteed renewable policies on a class basis.

Health Plan means any individual, general, blanket or group policy of health, accident or sickness insurance issued by an insurer licensed under M.G.L. c. 175 or the laws of any other jurisdiction; a hospital service plan issued by a non-profit hospital service corporation pursuant to M.G.L. c. 176A or the laws of any other jurisdiction; a medical service plan issued by a medical service corporation pursuant to M.G.L. c. 176B or the laws of any other jurisdiction; a health maintenance contract issued by a health maintenance organization pursuant to M.G.L. c. 176G or the laws of any other jurisdiction; and an insured health benefit plan that includes a preferred provider arrangement issued pursuant to M.G.L. c. 1761 or the laws of any other jurisdiction.

High-Pressure Tactics means employing any method of marketing that has the effect of or tends to induce or recommend the purchase of any insurance policy through force, fright, threat (whether explicit or implied) or undue pressure.

Individual Policy means a policy issued by a carrier directly to an insured.

Insured means the named policyholder or certificate-holder under a specified disease policy.

Noncancelable means the policy feature that guarantees the insured's right to continue the policy in force at the same premium level by the timely payment of premiums. A carrier cannot cancel, cannot decline to renew, cannot make any unilateral change in any provision of coverage and cannot revise premium rates for a noncancelable policy without the agreement of the insured.

Policy means an individual specified disease policy or a certificate of a group specified disease policy that is not employment-based, as well as the policy applications, riders, amendments or other provisions that are attached to the policy to identify the contractual provisions of the insured's coverage.

Pre-existing Condition means a medical condition for which an insured received diagnosis or treatment during the six-month period prior to the effective date of coverage.

Specified Disease Coverage means a policy which pays benefits on an indemnity or lump sum basis for the diagnosis and/or treatment of the disease or diseases.

146.05: General Standards for Individual Policies

(1) An individual policy covering a single specified disease or combination of specified diseases may not be sold or offered for sale other than as specified disease coverage pursuant to 211 CMR 146.00. An individual specified disease insurance policy shall cover all forms of the disease or diseases specified in the policy.

(2) Any individual specified disease policy issued which conditions payment upon pathological diagnosis of a covered disease, shall also provide that if such a pathological diagnosis is medically inappropriate or life threatening, a clinical diagnosis will be accepted in lieu thereof. Any form of medically appropriate diagnosis shall be accepted.

(3) An individual specified disease policy shall be either guaranteed renewable or noncanceable.

(4) Except for any policy provision regarding other specified disease coverage with the same insurer, benefits for specified disease coverage shall be paid regardless of other coverage.

(5) An individual specified disease policy may only include pre-existing condition limitations which exclude coverage for no more than six months after the effective date of coverage under the policy. The pre-existing condition limitation may only apply to a condition for which medical advice was given or treatment was recommended by, or received from, a licensed health care provider within the six-month period immediately preceding the effective date of coverage. If an individual specified disease policy contains any limitation with respect to pre-existing conditions, such limitations shall appear as a separate paragraph in the policy and shall be labeled as "Pre-Existing Condition Limitations".

(6) No policy shall provide for a reduction of benefits upon attainment of any age or other condition, or upon the occurrence of any event(s).

146.06: Minimum Benefit Standards for Individual Policies Written on an Indemnity and Recurring Basis

(1) Notwithstanding any other provisions of 211 CMR 146.06, an individual policy shall provide benefits to any covered person not only for the specified disease(s) but also for any other condition(s) or disease(s) directly caused or aggravated by the specified disease(s) or the treatment of the specified disease(s).

(2) If payments are to be conditioned upon a covered person receiving medically necessary care or treatment, given in a medically appropriate location, under a medically accepted course of diagnosis or treatment, this is to be clearly stated in the policy and the carrier must be accredited pursuant to M.G.L. c. 176O and 211 CMR 146.000.

(3) No individual policy or certificate issued pursuant to 211 CMR 146.06 shall contain a waiting period lasting longer than 30 days from the coverage effective date. A provision shall be included in the policy or certificate indicating that for a specified disease diagnosed within the initial 30 days of coverage, the policy or certificate is either void from its beginning with a full premium refund to the insured, or the coverage for such diagnosed specified disease is subject to a pre-existing condition limitation not exceeding six month from the coverage effective date. The provision shall also indicate that the insured must elect whether the policy or certificate is to be voided with a full premium refund or coverage is to be delayed.

(4) Except as otherwise noted in 211 CMR 146.06, an individual specified disease policy's benefits shall begin with the first day of medical care or hospital confinement if such care or confinement is for a covered disease, even though the diagnosis is made at some later date.

(5) Benefits for confinement in a skilled nursing home or for home health care are optional. If a policy or certificate provides these benefits, the coverage must equal a fixed sum payment of at least one-half of the hospital confinement in-patient benefit for each day of skilled nursing home confinement for at least 100 days, and a fixed sum payment of at least 1/2 of the hospital confinement in-patient benefit for each day of home health care for at least 100 days. Notwithstanding any other provision of this Part, any restriction or limitation applied to the benefits in the above requirements, whether by definition or otherwise, shall be no more restrictive than those under title XVIII of the Social Security Act (42 U.S.C. 1395c et seq., 1395j et seq.).

(6) If benefits are not payable for a period of 180 days, then a covered person shall be entitled to a new benefit period.

146.07: Minimum Benefit Standards for an Individual Policy Where a Benefit is a Lump-sum Payment for the Diagnosis of a Specified Disease without Further Coverage for Treatment of the Disease

(1) An individual specified disease policy may only be offered with face value amounts in even increments of $1,000 not to exceed $500,000. Carriers may offer a plan with benefits based on a percent of the face amount that results in less than an even $1,000 benefit.

(2) No individual policy or certificate issued pursuant to 211 CMR 146.07 shall contain a waiting period lasting longer than 30 days from the coverage effective date. A provision shall be included in the policy or certificate indicating that for a specified disease diagnosed within the initial 30 days of coverage, the policy is either void from its beginning with a full premium refund to the insured, or the coverage for such diagnosed specified disease is subject to a pre-existing condition limitation not to exceed six month from the coverage effective date. The provision shall also indicate that the insured must elect whether the policy or certificate is to be voided with a full premium refund or coverage is to be delayed.

(3) Indemnity amounts for any one specified disease cannot be required to be paid in more than two equal installments for any reoccurrences or spread of the same specified disease or a new primary occurrence of the same specified disease or the resulting death of the insured due to the same specified disease.

(4) New waiting periods for any one specified disease cannot be instituted for any reoccurrences or spread of the same specified disease or a new primary occurrence of the same specified disease. Waiting periods in addition to those allowed by 211 CMR 146.07(2) are prohibited. However, the insurer can require reasonable and appropriate medical certification that the insured is afflicted with a specified disease covered by the policy.

(5) Benefit amounts payable for any one specified disease can be subject to a maximum policy benefit for all specified diseases covered under the policy.

(6) A benefit shall always be payable upon initial and medically appropriate diagnosis of the specified disease covered by the policy. There shall be no requirement that the insured survive for any period of time in order for the benefit to be payable.

146.08: Form and Rate Filing Procedures for Individual Policies

(1) Carriers shall file all individual policy forms, including applications, disclosure statements and replacement forms, and associated rates pursuant to the provisions of 211 CMR 42.06.

(2) Applications forms must meet the requirements set forth in 211 CMR 42.08, 211 CMR 42.09(2), 211 CMR 42.99, M.G.L. c.175I and any other applicable Massachusetts statute or regulation.

(3) All rate filings are to specify the rates proposed to be charged to all underwriting classes. The rate filing is to define each underwriting class in a way to make clear how it will be applied to any occupation, actual or expected health condition, claims experience, duration of coverage or medical condition of such person in relation to 211 CMR 42.00 and M.G.L. c.175, § 108.

(4) In the event that any provision of 211 CMR 42.00 is inconsistent with the provisions of 211 CMR 146.00, the provisions of 211 CMR 146.00 shall govern all matters concerning any policy form that is within the definition of specified disease coverage in 211 CMR 146.00.

146.09: Requirements for Agent Training and Marketing

(1) Each carrier shall provide appropriate training to agents about its specified disease insurance products, maintain records regarding agents who have satisfactorily completed such training and file at least annually with the commissioner lists identifying those agents who have completed the carrier's specified disease insurance training program. No agent may offer for sale a company's product unless the agent is identified on the list filed with the Commissioner.

(2) All specified disease insurance marketing and advertising shall conform to the provisions of 211 CMR 40.00. In addition, carriers shall establish auditable internal marketing procedures, methods for assuring compliance by agents, and prohibitions against twisting, high-pressure tactics and cold-lead advertising. No advertisement of a policy shall imply coverage beyond the terms of the policy. Synonymous terms shall not be used to refer to any disease so as to imply broader coverage than is the fact.

(3) All agents or persons marketing a carrier's specified disease insurance shall clearly identify which plans being offered are individual products and which are group products. When marketing group products, the agent shall clearly identify the name of the group policyholder and any conditions that the eligible person must satisfy to join and remain a member of the group.

(4) All agents marketing a carrier's specified disease insurance shall disclose to potential applicants the name of the carrier that the agent represents in the sale. The carrier's name must be disclosed on any and all printed sales or appropriate materials provided, distributed or shown to potential applicants and/or during presentations made to potential applicants in association with a sale, whether part of a presentation or not.

(5) All agents marketing a carrier's specified disease insurance policy must disclose the fact that the agent receives compensation in connection with the sale or replacement of all specified disease insurance.

(6) All agents marketing a carrier's specified disease insurance shall not misrepresent their expertise, qualifications or training to potential clients and shall not comment on the legal or tax implications of purchasing specified disease insurance to the extent that they lack the training, qualifications or license to provide such advice.

(7) A carrier whose agent fails to comply with any provisions of 211 CMR 146.00, including but not limited to 211 CMR 146.09, will be deemed to have committed an unfair and deceptive act in the business of insurance subject to M.G.L. c.176D.

146.10: Requirements for Disclosure

All individual and group policies of specified disease insurance must adequately disclose all policy provisions, including but not limited to the following provisions;

(1) The first page of the policy must include the following:

(a) The following statement in 14-point boldface type: "Notice to buyer: This insurance provides a limited benefit in the event you are diagnosed with [the specified disease or diseases]. This policy is a supplement and not a substitute for a health benefit plan. You must have a health benefit plan in order to purchase this insurance.

(b) A section in boldface type that lists all pre-existing condition exclusions or limitations or clearly refers to the separate or stand-alone section within the policy that lists all pre-existing condition exclusions or limitations.

(c) A section that clearly identifies whether the policy is noncancelable or guaranteed renewable, and whether it is being issued on other than an individual basis (policies providing conversion privileges must specify the benefits to be provided or must state that the converted coverage shall be on the policy form then being issued by the carrier for this purpose).

(2) Policy Language.

(a) All terms used in the policy must be fully explained so that the insured understands their relationship to the benefits. No misleading policy names may be used. The policy, riders and all amendments, as well as application, outline of coverage and other requires disclosure materials distributed to any potential applicant must be presented in and must satisfy the readability standards of M.G.L. c. 175, § 2B.

(b) Riders or endorsements that provide a benefit for which a specific premium is charged must show the premium on the application, rider, or elsewhere in the policy. Any rider that reduces benefits requires a signed acceptance by the certificateholder.

(3) Disclosure Form. No specified disease insurance policy may be delivered or issued for delivery in Massachusetts unless the applicant receives a disclosure as set forth in 211 CMR 146.100, if communications occur with potential applicants prior to meeting with a company's agent. In the case of face-to- face meetings between an agent and potential insured, the carrier or its agent must deliver the disclosure prior to the presentation of the application or enrollment form. In the case of direct response sales, or enrollment by telephone, internet or self-enrollment as part of an employee benefits package, the carrier must deliver the form at the time the application or enrollment form is sent to the potential insured.

(4) Outline of Coverage. No specified disease insurance policy may be delivered or issued for delivery in Massachusetts unless the applicant receives an outline of coverage as set forth in 211 CMR 146.101. The carrier or its agent must deliver the outline of coverage prior to the presentation of the application or enrollment form. In the case of direct response sales, the carrier must deliver the outline of coverage at the time that the application or enrollment form is sent to the potential insured. The carrier must also make an outline of coverage available at any time at the potential insureds request. The outline of coverage must be a document separate from the policy.

(5) Application forms shall include questions designed to elicit the following:

(a) Whether, as of the date of the application, the applicant and all dependents being considered for the specified disease policy are covered by a Health Plan. If the applicant does not respond affirmatively to such question, the policy shall not be issued.

(b) Whether, as of the date of the application, the applicant and any dependents being considered for the specified disease policy have in force and/or applications pending for another specified disease policy or certificate for the same specified disease with the same or a different insurer, and whether the insurance applied for is intended to replace any of this coverage, and

(c) The number of specified diseases for which the applicant and any dependents being considered for the specified disease policy have coverage in-force as of the date of application and/or the number of application(s) pending as of the date of application.

146.11: Prohibition Against Post Claims Underwriting

(1) All applications and enrollment forms for individual and group specified disease insurance policies, except those that are guaranteed issue, shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant, including information regarding the health history of the applicant. Carriers are also required to provide, along with these forms, a clear explanation in writing of the applicant's rights as set forth in M.G.L. c.1751.

(2) If an application or enrollment form contains a question that asks whether the applicant has had medication prescribed by a physician, then it must also ask the applicant to list the medication that has been prescribed and the reason that the medication was prescribed.

(3) Except for policies that are guaranteed issue:

(a) The following language shall be set out conspicuously near the applicant's signature block on an application:

"Caution: If your answers on this application are incorrect or untrue, [carrier] has the right to deny benefits or rescind your policy."

(b) The following language, or language substantially similar to the following, shall be set out conspicuously on the policy, as well as the outline of coverage, at the time of delivery:

"Caution: The issuance of this specified disease [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers were incorrect or untrue as of the date you signed the application, the carrier has the right to deny benefits or rescind your policy subject to the [time limit on certain defenses, incontestable] section of your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the carrier at this address: [insert address]".

(4) A carrier shall deliver a copy of the completed application or enrollment form to the insured no later than at the time of delivery of the policy unless the form was retained by the insured at the time of application.

(5) Every carrier selling or issuing individual or group specified disease insurance policies in Massachusetts shall maintain a record of all individual policy or group certificate rescissions, on a state basis, except those that the insured voluntary effectuated, and shall furnish this information to the commissioner upon request.

146.12: Experience Monitoring Calculation

(1) Each carrier shall collect and file with the Commissioner by June 30 of each year, addressed to the Director of the State Rating Bureau, the following experience data contained in the form prescribed by the Commissioner in 211 CMR 146.102: Appendix A for each calendar year since inception, for all years accumulated at the interest assumptions used in the applicable expected durational loss ratio: Earned Premium, Incurred Claims, Actual Durational Loss Ratio and Expected Durational Loss Ratio. The calculation shall include Massachusetts experience when credible and national experience when Massachusetts experience is not credible. The carrier shall clearly specify in any calculations whether the experience reported is nationwide or for Massachusetts only.

(2) If on the basis of the experience data as reported, the carrier's Expected Durational Loss Ratio exceeds its Actual Durational Loss Ratio, then the carrier shall compare the ratio of its Actual Durational Loss Ratio to its Expected Durational Loss Ratio using the following chart in order to determine whether a corrective action is required:

Number of Reported Claims in the Period	Ratio Indicating that Insurer Action is Necessary
1.000 or more	0.90 or less
100 - 999	0.80 or less
25 - 99	0.65 or less
0 - 24	0 or less

(3) If corrective action is required according to the foregoing chart, a carrier shall comply with the following:

(a) A preliminary plan outlining the policy forms which require carrier corrective action shall be made with the June 30 filing. If, in the opinion of the carrier's actuary, the ratio indicating that insurer action is necessary is due to unusual reserve fluctuations, economic conditions, or other nonrecurring conditions, the preliminary plan should include that opinion, with appropriate justification. In such a case, the Commissioner may exempt the policy form from the need for a corrective action plan for that year. Filing of the final corrective action plan itself shall be made by the later of October 1 or three months from the date of denial of the exemption, and must contain the information required under 211 CMR 42.06(2).

(b) For policies that are not noncancelable, a corrective action plan shall demonstrate the plan proposing to reduce premiums, apply dividends, increase benefits, or use any combination of these or other methods to make corrections so that the carrier's specified disease product can achieve, as certified by an actuarial fellow as satisfying sound and reasonable actuarial principles, the loss ratio level that was part of the original policy filing with the State Rating Bureau and that satisfied the requirements of 211 CMR 42.06. Any such plan is subject to approval by the Commissioner and any plan to increase benefits may not be included as part of the insurer's plan without offering the alternative option of appropriate premium reductions. Failure to submit such a plan within the required time period will be a violation of 211 CMR 146.00 and will subject the insurer to the penalties of M.G.L. c. 175, § 189.

(c) For policies that are noncancelable, a corrective action plan shall demonstrate the continued reasonableness of the benefits in relation to premiums, as certified by an actuarial fellow as satisfying sound and reasonable actuarial principles, justifying continued use of the policy form or shall demonstrate any correction actions to reduce premiums, apply dividends, increase benefits, or use any combination of these or other methods to make corrections so that the carrier's specified disease product can achieve, as certified by an actuarial fellow as satisfying sound and reasonable actuarial principles, the loss ratio level that was part of the original policy filing with the State Rating Bureau to satisfy the requirements of 211 CMR 42.06. Any such plan is subject to approval by the Commissioner and any plan to increase benefits may not be included as part of the insurer's plan without offering the alternative option of appropriate premium reductions. Failure to submit such a plan within the required time period will be a violation of 211 CMR 146.000 and will subject the insurer to the penalties of M.G.L. c. 175, § 189.

146.13: Severability

If any section or portion of a section of 211 CMR 146.00, or the applicability thereof to any person or circumstance is held invalid by any Court of competent jurisdiction, the remainder of 211 CMR 146.00, or the applicability thereof to other persons or circumstances, shall not be affected thereby.

146.100: Policy Disclosure Form

(1) Policies of individual insurance and certificates and policies of group insurance shall use the following prescribed statement only, except that appropriate policy and certificate identification may be included:

COMPANY NAME

SPECIFIED DISEASE COVERAGE ONLY

REQUIRED DISCLOSURE STATEMENT

This policy or certificate is (an individual policy of insurance) (a group policy or certificate). This policy or certificate provides specified disease coverage ONLY. This policy or certificate does NOT provide basic hospital, basic medical or major medical insurance. It is a supplement to your health benefit plan and cannot replace your health benefit plan.

(Accurately list benefits, exclusions, reductions and limitations of the policy or certificate in a manner which does not encourage misrepresentation of the actual coverage provided.)

This disclosure statement is a very brief summary of your policy or certificate.

The policy or certificate itself sets forth the rights and obligations of both you and the insurance company. It is therefore imperative that you READ YOUR POLICY OR CERTIFICATE carefully.

The expected benefit ratio for this policy or certificate is ___%. This ratio is the portion of future premiums which the company expects to return as benefits, when averaged over all people with this policy or certificate.

(2) Required Disclosure for Medicare-Eligible Applicants. Carriers shall provide the Guide to Health Insurance for People with Medicare and disclosure notice as required by 211 CMR 42.09(4).

146.101: Outline of Coverage

[CARRIER NAME]

[ADDRESS - CITY & STATE],[TELEPHONE NUMBER]

SPECIFIED DISEASE INSURANCE - OUTLINE OF COVERAGE

Policy Number:

1. This policy is [an individual policy of insurance/a group policy which was issued in (indicate jurisdiction in which group policy was issued)]. THIS IS A LIMITED POLICY.

[Except for policies or certificates that are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

Caution: The issuance of this specified disease insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue as of the date you signed the applications, the carrier has the right to deny benefits or rescind your policy subject to the [Time Limit on Certain Defenses, Incontestable] section of your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers were incorrect, contact the carrier at this address: [insert address]

2. SUMMARY OF POLICY FEATURES

This policy:

1. is not a Medicare Supplement policy.

2. [is guaranteed renewable/is noncancelable] for your lifetime.

3. [is/is not] subject to automatic premium increases as you get older.

4. [may be/is not] subject to across the board premium increases for all policyholders in your class.

5. [does/does not] offer an option to purchase inflation protection.

6. [does/does not] offer an option to purchase nonforfeiture protection.

7. [does/does not] contain special age limitations for purchase.

8. [does not cover services due to pre-existing conditions (existing health problems) for a period of __ months from policy issue][does not have a waiting period before pre-existing conditions (existing health problems) are covered].

9. [may have/has] a waiting period of __ days before benefits are payable by policy.

10. [offers a waiver of premium after __ days of __ benefits][does not offer a waiver of premium].

3. PURPOSE OF OUTLINE OF COVERAGE. An outline of coverage provides a very brief description of the important features of the coverage. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains actual contractual provisions. This means that your [policy/certificate] sets forth in detail the rights and obligations of both you and the carrier. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR [POLICY/CERTIFICATE] CAREFULLY!

4. TERMS UNDER WHICH THE [POLICY/CERTIFICATE] MAY BE CONTINUED IN FORCE OR DISCONTINUED.

(a) [For specified disease insurance policies or certificates describe one of the following permissible policy renewability provisions:

(1) Policies and certificates that are guaranteed renewable must contain the following statement:] RENEWABILITY: THIS [POLICY[/CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy, to continue this coverage as long as you pay your premiums on time. [Carrier Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

OR

(1) Policies and certificates that are noncancelable must contain the following statement:] RENEWABILITY: THIS [POLICY/CERTIFICATE] IS NONCANCELABLE. This means you have the right, subject to the terms of your policy, to continue this coverage as long as you pay your premiums on time. [Carrier Name] cannot change any of the terms of your policy on its own without your agreement, and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Carrier Name] may increase your premium at that time for those additional benefits.

OR

(1) Policies and certificates that are convertible from a group policy must contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS CONVERTIBLE TO AN INDIVIDUAL POLICY.](For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy:]

(b) [Describe waiver of premium provisions or state such provisions are not in the policy.]

(c) [State whether or not the carrier has a right to change premium, and if the right exists, describe clearly and concisely each circumstance under which premium may change, including that it is subject to the commissioner's approval.]

5. TERMS UNDER WHICH THE [POLICY/CERTIFICATE] MAY BE RETURNED AND PREMIUM REFUNDED.

(a) [Provide a brief description of the right to return--the policy's "free look" provision, which must be a minimum of ten days from the date of policy delivery.]

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

6. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the carrier.

(a) [For agents] Neither [insert carrier name] nor its agents represent Medicare, the federal government, or any state government.

(b) [For direct response] [insert carrier name] is not representing Medicare, the federal government or any state government.

7. BENEFITS PROVIDED BY THIS [POLICY/CERTIFICATE].

(a) [Covered services, deductible(s), waiting periods, and maximums.]

[A policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import must include an explanation of such terms in this section of the outline of coverage.]

[Any benefit screening must be explained in this section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description.]

8. LIMITATIONS AND EXCLUSIONS

[Describe:

(a) Pre-existing conditions

(b) Non-eligible levels of care (e.g. unlicensed providers, care by a family member, etc.)

(c) Exclusions/exceptions

(d) Limitations]

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in (6) above.]

9. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

(a) That the benefit level will not increase over time;

(b) Any automatic benefit adjustment provisions;

(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by specified amount or percentage;

(d) If there is not a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;

(e) Describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

10. NONFORFEITURE BENEFITS (if applicable). As an accident and sickness policy, this policy does not have a cash value associated with life insurance products. This policy does offer [for an additional charge (if applicable)] a nonforfeiture benefit that will continue until exhausted even if the policy lapses due to nonpayment of policy premiums. The following represents an example of how this benefit would apply to your policy: [As applicable, indicate the following:

[Carriers must include the following information in or with the outline of coverage:

(a) A description of the benefits that would accrue at different periods of policy lapse

(b) Whether or not the benefit was chosen by the policyholder.]

11. PREMIUM.

[(a) State the total annual premium for the policy;

(b) If the premium varies with an applicant's choice of benefit options, indicate the portion of annual premium that corresponds to each benefit option; OR

(c) Refer individual to schedule page of the policy.]

COMPLAINTS. If you have a complaint, call your agent. If you are not satisfied, you may call or write the Massachusetts Division of Insurance, Consumer Services Section, One South Station, 5th Floor, Boston, MA 02110- 2208.

146.102: Appendix A - Specified Disease Insurance Experience Monitoring Form

MASSACHUSETTS SPECIFIED DISEASE INSURANCE EXPERIENCE MONITORING FORM
FOR
CALENDAR YEAR

Company _____

NAIC Group Code_____

NAIC Company Code_____

Address_____

Person Completing Form_____

Title_____

Telephone Number_____

Policy Form _____

[a]	[b]	[c]	[d]	[e] [d] / [c]	[f]
Calendar Year	Duration	Earned Premium [FN(1)]	Incurred Claims	Actual Durational Loss Ratio [FN(2)]	Expected Durational Loss Ratio [FN(3)], [FN(4)]

FN(1) Previously approved approximations may be used in lieu of actual Earned Premium by Duration.
FN(2) Actual Durational Loss Ratio is equal to Incurred Claims divided by Earned Premium.
FN(3) Expected Durational Loss Ratio for each Duration is equal to the

durational loss ratio most recently filed under 211 CMR 42.06.

FN(4) Expected Durational Loss Ratio for the calendar year is determined by:

(a) calculating the product of Expected Durational Loss Ratio for each Duration times the earned premium for each Duration;

(b) calculating the sum of each such product for each Duration in the calendar year; and

(c) dividing that sum by the earned premium for all Durations in the calendar year.