RESET

CHECKLIST: MEDICARE SUPPLEMENT PLAN
FORM FILING
Pursuant to the Requirements of M.G.L. c. 176K and 211 CMR 71.00

- **F*or each requirement, indicate the page number(s), and/or section(s), where the required information is located.***
- ***For items requiring company confirmation, place a checkmark√) next to the requirement acknowledging confirmation.***
- ***If a requirement is not applicable, place "N/A" next to the requirement and explain, either within the checklist or on a separate sheet, the <u>legal basis</u> under which the requirement does not apply to the filed materials.***

Carrier Name & NAIC #: _____

Product Name(s) & Form #(s):
(Please attach a separate sheet if necessary to identify all forms submitted with the filing.) _____

_____

$ 75 filing fee remitted pursuant to 801 CMR 4.02(28) _____

$ 150 filing fee remitted pursuant to 801 CMR 4.02(28) _____

<u>Carrier Certification:</u>

I _____ a duly authorized representative of _____ certify that it is my good faith belief based on the review of this checklist and submitted materials that the submitted materials comply with applicable Massachusetts law.

FILINGS THAT DO NOT INCLUDE ALL APPLICABLE FULLY COMPLETED CHECKLISTS WILL BE RETURNED AND NOT REVIEWED.

FILING REQUIREMENTS 211 CMR 71.12(9)

_____ All submissions shall be submitted in a form specified by the Commissioner, unless granted a waiver from this requirement by the Division.

_____ Each submission shall be accompanied by Massachusetts Division of Insurance Medicare Supplement Checklist.

_____ Each form submitted for final approval must be printed, be a printer's proof, or be in the form in which it will be issued.

_____ Each form shall display an identification code on the lower left-hand corner of the first page.

_____ The submission of a rider, application or endorsement shall specify the Policy or group of Policies with which it will be used. The identification code of such Policy or group of Policies shall be given together with, if possible, the approximate date of the original filing to expedite review. If a new form makes reference to the provisions of a form previously used that did not require filing or approval, it shall be accompanied by such previous form for reference purposes.

_____ Revisions shall not be made by rider, endorsement or amendment, except with prior approval of the Commissioner. No such riders, endorsements or amendments shall be submitted for approval unless the Issuer is notified in advance by the Commissioner that revision by rider, endorsement or amendment is permissible.

_____ All submitted material shall be filled in with appropriate hypothetical data.

_____ Applications to be attached to Policy forms upon issue must be attached to such forms upon submission. If such an application was previously filed and approved, the approximate date of such approval must be noted, if possible. Policy outlines of coverage prescribed in 211 CMR 71.13 must also be filed with the corresponding Policy forms, as well as application forms and notices pursuant to 211 CMR 71.14.

_____ The cover letter must state whether the form is new or replaces an approved or previously filed form or forms.

_____ If a form replaces a previously approved or filed form, the identification code of the replaced form must be given and differences from the text of the replaced form must be noted. Where an entire form has been rewritten to improve its readability, a general description of changes is sufficient. Substantive changes shall be carefully noted.

_____ If a form was previously disapproved, this fact must be set forth in the cover letter with the reasons why the form is resubmitted.

READABILITY STANDARDS 211 CMR 71.04 AND M.G.L. C. 175 §2B:

_____ Filing includes certification by company official that each form meets standards of M.G.L. c. 175 §2B. The term "text" includes all printed matter except the name and address of the insurer, name or title of the policy, captions and subcaptions, and schedule pages and tables used in the policy. M.G.L. c. 175 §2B

___ Text of each form achieves minimum Flesch score of 50 as stated in certification. (A statement to the effect that the score exceeds 50 is not permitted.)

___ a. It is printed, except for tables, in not less than twelve-point type, one point leaded.

___ b. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the text of the policy and any endorsements or riders;

___ c. It contains a table of contents or an alphabetical subject index;

___ d. The width of margins and ink to paper contrast do not interfere with the readability of the form; and

___ e. The organization of the content of the policy and the summary of the policy are conducive to understandability of the form.

_____ If insurer feels that any form is exempt from M.G.L. c. 175 §2B, state reason for exemption in cover letter.

STANDARDS FOR POLICY DEFINITIONS 211 CMR 71.05:

_____ All definitions used in a Medicare Supplement Insurance Policy shall be compatible with Medicare definitions and practice.

ALL MEDICARE SUPPLEMENT INSURANCE POLICIES SHALL INCLUDE A DEFINITION FOR THE FOLLOWING TERMS:

_____ **Accident, Accidental Injury, or Accidental Means** shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

(a) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

(b) The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, motor vehicle no-fault plan, or other motor vehicle insurance related plan, unless prohibited by law.

_____ **Benefit Period or Medicare Benefit Period** shall not be defined more restrictively than as defined in the Medicare program.

_____ **Convalescent Nursing Home, Extended Care Facility, or Skilled Nursing Facility** shall not be defined more restrictively than as defined in the Medicare program. The definition must take into account that there are Policy benefits for these providers' services which are paid for only by the Medicare Supplement Insurance Policy and for

which Medicare does not contribute payment.

_____ **Hospital** may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but shall not be defined more restrictively than as defined in the Medicare program. The definition must take into account that there are Policy benefits for these providers' services which are paid for only by the Medicare Supplement Insurance Policy and for which Medicare does not contribute payment.

_____ **Medicar**e shall be defined in the Policy and Certificate. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended, or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof."

_____ **Medicare Eligible Expenses** shall mean expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

_____ **Physician** shall not be defined more restrictively than as defined in the Medicare program. The definition must take into account that there are Policy benefits for this provider's services which are paid for only by the Medicare Supplement Insurance Policy and for which Medicare does not contribute payment.

_____ Sickness shall not be defined more restrictively than the following:
Sickness means illness or disease of an insured person for which expenses are incurred after the effective date of insurance and while the insurance is in force. The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

POLICY LIMITATIONS 211 CMR 71.06:

_____ No Medicare Supplement Insurance Policy shall be advertised, solicited, issued, renewed, delivered or issued for delivery which contains any waiting period or pre-existing condition limitation or exclusion.

_____ No Medicare Supplement Insurance Policy shall contain limitations or exclusions on coverage that are more restrictive than those of Medicare.

_____ Limitations on benefits shall be so labeled in a separate section of the Medicare Supplement Insurance Policy as well as placed with the benefit provisions to which they apply.

_____ No Medicare Supplement Insurance Policy shall contain benefits that duplicate benefits provided by Medicare. No Medicare Supplement Insurance Policy offered or sold after December 31, 2005 shall provide payment for drugs or biologicals eligible for coverage under Medicare Part D.

ELIGIBILITY 211 CMR 71.03

_____ Eligible Person: Any person who is eligible for Medicare Part A and B and is enrolled in Medicare Part B regardless of age;

_____ provided, however, that Issuers and Health Maintenance Organizations are not required to provide coverage to a person who is under the age of 65 and eligible for Medicare coverage due solely to end-stage renal disease.

_____ provided, further, that nothing in 211 CMR 71.00 *et seq*. prevents an Issuer or an HMO from providing coverage to a person who is under the age of 65 and is eligible for Medicare coverage due solely to end-stage renal disease; and provided, further, that if an Issuer or an HMO determines that it will provide coverage to people who are under the age of 65 and eligible for Medicare coverage due solely to end-stage renal disease, it shall do so in accordance with all of the provisions of 211 CMR 71.00 *et seq*.

_____ If a BBA Eligible Person also meets the requirements of being Initially Eligible for Coverage, as defined in 211 CMR 71.03, the individual shall be entitled to guarantee issue of all plans currently available from an Issuer as specified in 211 CMR 71.10(4), including the time periods specified. See 211 CMR 71.10(13)(a) for the definition of a BBA (the federal Balanced Budget Act or 1997 (P.L. 105-33) eligible person.

_____ If MMA Eligible Persons also meet the requirements of being Initially Eligible for Coverage, as defined in 211 CMR 71.03, the individuals shall be entitled to guaranteed coverage under all Policies currently available from an Issuer as specified in 211 CMR 71.10(4), including the time periods specified. See 211 CMR 71.10(14)(a) for the definition of a MMA (federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003) Eligible Person.

RENEWABILITY 211 CMR 71.07:

_____ All Medicare Supplement Insurance Policies, including Alternate Innovative Benefit Riders, shall contain a renewability provision as required by 211 CMR 71.07(1). Such provision shall be appropriately captioned and shall appear on the first page of the Policy and shall include any reservation by the Issuer of the right to change premiums.

MEDICARE SUPPLEMENT INSURANCE POLICIES SHALL COMPLY WITH THE FOLLOWING REQUIREMENTS:

_____ The Issuer shall not cancel or nonrenew the Policy solely on the ground of the health status of the individual.

_____ The Issuer shall not cancel or nonrenew the Policy, including an Alternate Innovative Benefit Rider, for any reason other than nonpayment of premium or material misrepresentation; provided that no Nonprofit Hospital Service Corporation or Medical Service Corporation shall be required to continue the coverage of a Policyholder who becomes a resident of a state other than Massachusetts.

_____ If the Medicare Supplement Insurance Policy is terminated by the **group** Policyholder and is not replaced as provided under 211 CMR 71.07(3)(e), the Issuer shall offer certificateholders an individual Medicare Supplement Insurance Policy which, at the option of the certificateholder:

1. Provides for continuation of the benefits contained in the group Policy; or
2. Provides for benefits that otherwise meet the requirements of 211 CMR 71.07(3).

_____ If an individual is a certificateholder in a group Medicare Supplement Insurance Policy and the individual terminates membership in the group, the Issuer shall:

1. Offer the certificateholder the conversion opportunity described in 211 CMR 71.07(3)(c); or
2. At the option of the group Policyholder, offer the certificateholder continuation of coverage under the group Policy.

_____ If a group Medicare Supplement Insurance Policy is replaced by another group Medicare Supplement Insurance Policy purchased by the same Policyholder, the Issuer of the replacement Policy shall offer coverage to all persons covered under the old group Policy on its date of termination. Coverage under the new Policy shall not contain any waiting period or preexisting condition limitation or exclusion.

_____ Termination of a Medicare Supplement Insurance Policy shall be without prejudice to any continuous loss which commenced while the Policy was in force, but the extension of benefits beyond the period during which the Policy was in force may be conditioned upon the continuous total disability of the Insured, limited to the duration of the Policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

_____ A Medicare Supplement Insurance Policy shall provide that benefits and premiums under the Policy shall be suspended at the request of the Policyholder for the period (not to exceed 24 months unless the Issuer permits a longer period of suspension) in which the Policyholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the Policyholder notifies the Issuer of such Policy within 90 days after the date the individual becomes entitled to such assistance.

_____ If suspension occurs and if the Policyholder loses entitlement to medical assistance, the Policy shall be automatically reinstituted (effective as of the date of termination of such entitlement) if the Policyholder provides notice of loss of entitlement within 90 days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

_____ Each Medicare Supplement Insurance Policy shall provide that benefits and premiums under the Policy shall be suspended (for any period that may be provided by federal regulation) at the request of the Policyholder if the Policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the Policyholder loses coverage under the group health plan, the Policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the Policyholder provides notice of loss of coverage within 90 days after the date of the loss.

_____ Reinstitution of such coverages as described in 211 CMR 71.07(3)(g)3. and 4.:

a. Shall not provide for any waiting period with respect to treatment of preexisting conditions;
b. Shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension. If the suspended Medicare Supplement Insurance Policy provided coverage for outpatient prescription drugs, reinstitution of the Policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and
c. Shall provide for classification of premiums on terms at least as favorable to the Policyholder as the premium classification terms that would have applied to the Policyholder had the coverage not been suspended.

Policy Benefit Standards 211 CMR 71.08:

A Medicare Supplement Insurance Policy shall not be advertised, solicited, delivered, issued, issued for delivery or renewed unless the Policy meets the following requirements:

_____ A Medicare Supplement Insurance Policy shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

Any Medicare Supplement Insurance Policy shall provide that benefits designed to cover cost sharing amounts under Medicare.

_____ will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors

_____ and any Medicare Supplement Insurance Policy issued to be effective on or after January 1, 2006 shall provide that benefits will be changed automatically to coincide with any changes required under Massachusetts law regarding mandated benefits;

_____ premiums may be modified to correspond with such changes, if approved by the Commissioner in accordance with statutory and regulatory requirements; provided, however, that such Policy shall provide that the Insured agrees to the change of benefits and premiums based on changes required under Massachusetts law regarding mandated benefits;

_____ and provided, further, that, except as otherwise required by law, all Medicare Supplement Insurance Policies originally issued to be effective prior to January 1, 2006 shall maintain any Guaranteed Renewable fixed drug deductible and the same benefits covered in the original Policy

_____ No Medicare Supplement Insurance Policy shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the Insured, other than the nonpayment of premium.

_____ Each Medicare Supplement Insurance Policy shall be Guaranteed Renewable in accordance with the provisions of 211 CMR 71.07.

_____ No Medicare Supplement Insurance Policy issued to be effective on or before December 31, 2005, which provides coverage for prescription drugs, shall exclude coverage of any such drug for the treatment of cancer or HIV/AIDS on the ground that the off-label use of the drug has not been approved by the United States Food and Drug Administration for that indication; provided, however, that such drug is recognized for treatment of such indication in one of the standard reference compendia; or in the medical literature, as those terms are defined in M.G.L. c. 175, § 47O, or by the Commissioner under the provisions of M.G.L. c. 175, § 47P.

_____ An Issuer of a Medicare Supplement Insurance Policy shall refund the unearned portion of any premium paid on a quarterly, semi-annual or annual basis upon the death of a Policyholder. An Issuer of a Medicare Supplement Insurance Policy may refund the unearned portion of any premium paid on a quarterly, semi-annual or annual basis in the case of cancellation by the Policyholder for reasons other than death. When calculating all such refunds, an Issuer of a Medicare Supplement Insurance Policy shall convert the billing mode from annual, semi-annual, or quarterly to monthly as of the date of death or cancellation by the Policyholder for reasons other than death and refund the premium paid less the sum of the monthly premiums earned to that point or use a refund methodology submitted to and approved by the Commissioner. All Medicare Supplement Issuers shall notify applicants regarding premium refunds in the required outline of coverage as set forth in 211 CMR 71.13(2)(c)2. Nothing in 211 CMR 71.08(1)(h) shall affect the rights of a Policyholder to return the Policy within 30 days of its delivery and receive a premium refund pursuant to 211 CMR 71.13 (1)(e).

STANDARDS FOR CLAIMS PAYMENT 211 CMR 71.11 AND M.G.L.C.175 §110

An Issuer of Medicare Supplement Insurance shall comply with section 1882(c)(3) of the Social Security Act (as enacted by section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203) by:

_____ Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice.

_____ Notifying the participating physician or supplier and the beneficiary of the payment Determination.

_____ Paying the participating physician or supplier directly.

_____ Furnishing, at the time of enrollment, each enrollee with a card listing the Policy name, number and a central mailing address to which notices from a Medicare carrier may be sent.

_____ Within forty-five days from . . . receipt of notice [of a claim by a claimant] if payment is not made the insurer shall notify the claimant in writing specifying the reasons for the nonpayment or whatever further documentation is necessary for payment of said claim within the terms of the policy. If the insurer fails to comply with the provisions of this paragraph, said insurer shall pay, in addition to any benefits which inure to such claimant or provider, interest on such benefits, which shall accrue beginning forty-five days after the insurer's receipt of notice of claim at the rate of one and one-half percent per month, not to exceed eighteen percent per year. The provisions of this paragraph relating to interest payments shall not apply to a claim which an insurer is investigating because of suspected fraud.

REQUIRED DISCLOSURE PROVISIONS 211 CMR 71.13

_____ Except for riders or endorsements by which the Issuer effectuates a request made in writing by the Insured, exercises a specifically reserved right under a Medicare Supplement Insurance Policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare Supplement Insurance Policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the Policy shall require a signed acceptance by the Insured. After the date of Policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the Policy term shall be agreed to in writing signed by the Insured, unless the benefits are required by the minimum standards for Medicare Supplement Insurance Policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the Policy.

_____ Each Policy shall have a notice prominently printed on the first page of the Policy or attached thereto stating in substance that the Policyholder shall have the right to return the Policy within 30 days of its delivery and to have the premium refunded if, after examination of the Policy, the insured person is not satisfied for any reason.

_____ Each Policy shall not provide for the payment of benefits based on standards described as usual and customary," "reasonable and customary," or words of similar import.

_____ Each Policy shall have a specification page and shall provide the following information:

1. The Policy number;
2. The name of the Insured;
3. The effective date, assuming the premium for the Policy has been paid on or before that date;
4. A listing of the premium or premiums payable and the periods to which they apply.

_____ No misleading Policy names shall be used. A carrier's Policy name shall not misrepresent the extent of benefits actually provided. Carriers shall not use the name "Medicare Supplement," "Medigap" or similar terms except to describe a Policy that complies with 211 CMR 71.00.

MEDICARE SUPPLEMENT CORE POLICY 211 CMR 71.90

A Medicare Supplement Core Insurance Policy shall provide the following coverage and shall not provide any additional benefits:

_____ The following Medicare Part A eligible expenses:
(a) To the extent not covered by Medicare, benefits for hospitalization for the first 90 days per benefit period less the Medicare Part A deductible, plus 60 lifetime reserve days, then an additional lifetime maximum of 365 days paid at the applicable prospective payment system rate or other appropriate Medicare standard of payment. The provider shall accept the Issuer's payment as payment in full and may not bill the insured for any balance. Such benefits shall include treatment for biologically-based mental disorders and charges for the first three pints of blood.
(b) To the extent not covered by Medicare, for biologically-based mental disorders, stays in a licensed mental hospital, less Part A deductibles; for other mental disorders benefits, stays in a licensed mental hospital for at least 60 days per calendar year less days covered by Medicare or already covered by the plan in that calendar year for other mental disorders, less Part A deductibles.

_____ The following Medicare Part B eligible expenses: To the extent not covered by Medicare, the Medicare Part B coinsurance or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of pocket amount equivalent to the Medicare Part B deductible [$100]. This includes all costs for the first three pints of blood.

_____ Services rendered for the treatment of mental disorders on an outpatient basis:
a. For biologically-based mental disorders:
   1. By a provider covered by Medicare, the benefit described in 211 CMR 71.90(2).
   2. By a provider not covered by Medicare, coverage for all medically necessary visits.

b. For other mental health disorders:
   1. By a provider covered by Medicare, the benefit described in 211 CMR 71.90(2).
   2. By a provider not covered by Medicare, a minimum of 24 medically necessary visits per 12-month period, less any visits already covered under 211 CMR 71.90(3)(a)(1), in the 12-month period. As required by M.G.L. c. 175, § 47B(i); M.G.L. c. 176A, § 8A(i); M.G.L. c. 176B §4A(i), psychopharmacological services and neuropsychological assessment services shall be treated as a medical benefit and shall be covered as described in 211 CMR 71.90(2). The benefit described in 211 CMR 71.90(3) is subject to 211 CMR 71.06(4).

_____ Enteral formulas medically necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, as required by M.G.L. c. 175, § 47I; M.G.L. c. 176A, § 8L; and M.G.L. c. 176B, § 4K, less any Medicare payments.

_____ Enteral formulas medically necessary for the treatment of inherited diseases of amino acids and organic acids as required by M.G.L. c. 175, § 47I; M.G.L. c. 176A, § 8L; and M.G.L. c. 176B, § 4K, less any Medicare payments. Coverage for inherited disease of

amino acids and organic acids shall include food products modified to be low protein in an amount not to exceed $5,000 annually for any Insured individual.

_____ Where applicable, as required under M.G.L. c. 175, § 47G, as amended from time to time, pap smear tests and mammograms not covered by Medicare.

_____ Bone marrow transplants or transplants for certain patients with breast cancer as required by M.G.L. c. 175, § 47M; M.G.L. c. 176A, § 8O (as added by St. 1993, c. 458, § 2); and M.G.L. c. 176B, § 4O not covered by Medicare. The benefit described in 211 CMR 71.90(6) is subject to 211 CMR 71.06(4).

_____ At the option of the Issuer, and if approved by the Commissioner, the New or Innovative Benefits outlined in 211 CMR 71.09(1) or (5). Such New or Innovative Benefits may be offered within the Policy or as an optional Alternate Innovative Benefit Rider to the Medicare Supplement Core Insurance Policy.

_____ Licensed hospice care services to terminally ill patients with a life expectancy of six months or less, as set forth and regulated by M.G.L. c. 111, § 57D and as authorized by a duly licensed physician as required by M.G.L. c. 175, § 47Q (as added by St. 1994, c. 284, § 2); M.G.L. c. 176A, § 8P (as added by St. 1994, c. 284, § 3); and M.G.L. c. 176B, § 4Q (as added by St. 1994, c. 284, § 4).

_____ Expenses incurred in the medically necessary diagnosis and treatment of speech, hearing and language disorders individuals licensed as speech-language pathologists or audiologists under M.G.L. c. 112, as required by M.G.L. c. 175, § 47U (as added by St. 2000, c. 345, § 2); M.G.L. c. 176A, § 8U (as added by St. 2000, c. 345, § 3); and M.G.L. c. 176B, § 4U (as added by St. 2000, c. 345, § 4).

_____ Hormone replacement therapy services for peri and post menopausal women and outpatient contraceptive services under the same terms and conditions as for such other outpatient services. Outpatient contraceptive services shall mean consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of all contraceptive methods to prevent pregnancy that have been approved by the United States Food and Drug Administration, as required by M.G.L. c. 175, § 47W(a) (as added by St. 2002, c. 49, §1); M.G.L. c. 176A, § 8W(a) (as added by St. 2002, c. 49, §2); M.G.L. c. 176B, § 4W(a) (as added by St. 2002, c. 49, §3); and/or M.G.L. c.176G, § 4O(a) (as added by St. 2002, c. 49, § 4). The benefit described in 211 CMR 71.90(12) is subject to 211 CMR 71.06(4).

_____ According to M.G.L. c. 175 §47AA, M.G.L. c. 176A §8DD M.G.L. c. 176B §4DD fully insured health plans **issued or renewed by health insurance carriers on and after January 1, 2011** must provide benefits for the diagnosis and treatment of ASD on a nondiscriminatory basis to all residents of Massachusetts and to all insureds having a principal place of employment in Massachusetts. [refer to above-noted statutes for a complete description of the mandate]

MEDICARE SUPPLEMENT 1 211 CMR 71.91

A Medicare Supplement 1 Insurance Policy shall provide the following coverage and shall not provide any additional benefits:

_____ The following Medicare Part A eligible expenses:
(a) To the extent not covered by Medicare, benefits for hospitalization for the first 90 days per benefit period, plus 60 lifetime reserve days, then an additional lifetime maximum of 365 days paid at the applicable prospective payment system or other appropriate Medicare standard of payment. The provider shall accept the Issuer's payment as payment in full and may not bill the insured for any balance. Such benefits shall include treatment for biologically-based mental disorders and charges for the first three pints of blood.
(b) To the extent not covered by Medicare, for biologically-based mental disorders, stays in a licensed mental hospital; for other mental disorders benefits, stays in a licensed mental hospital for a minimum of 120 days per benefit period (at least 60 days per calendar year) less days covered by Medicare or already covered by the plan in that calendar year for other mental disorders.
(c) Services in a skilled nursing facility certified by Medicare, during the first 100 days, to the extent not covered by Medicare, and $10 per day for the l01st through the 365th day per benefit period, provided the stay otherwise meets Medicare requirements. Benefits for services in all skilled nursing facilities shall be available for a combined maximum of 365 days per benefit period.

_____ Services in a skilled nursing facility not certified by Medicare at $8 per day for 365 days per benefit period, provided the admission otherwise meets Medicare requirements. Benefits for services in all skilled nursing facilities shall be available for a combined maximum of 365 days per benefit period.

_____ The following Medicare Part B eligible expenses: To the extent not covered by Medicare, the Medicare Part B deductible and coinsurance or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount for Medicare Part B eligible expenses regardless of hospital confinement. This includes all costs for the first three pints of blood.

_____ Services rendered for the treatment of mental disorders on an outpatient basis:
a. For biologically-based mental disorders:
1. By a provider covered by Medicare, the benefit described in 211 CMR 71.90(2).
2. By a provider not covered by Medicare, coverage for all medically necessary visits.

b. For other mental health disorders:
1. By a provider covered by Medicare, the benefit described in 211 CMR 71.90(2).
2. By a provider not covered by Medicare, a minimum of 24 medically necessary visits per 12-month period, less any visits already covered under 211 CMR 71.90(3)(a)(1), in the 12-month period. As required by M.G.L. c. 175, § 47B(i); M.G.L. c. 176A, § 8A(i); M.G.L. c. 176B §4A(i), psychopharmacological services and neuropsychological assessment services shall be treated as a medical benefit and shall be covered as described in 211 CMR 71.90(2). The benefit described in 211 CMR 71.90(3) is subject to 211 CMR 71.06(4).

_____ Enteral formulas medically necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, as required by M.G.L. c. 175, § 47I; M.G.L. c. 176A, § 8L; and M.G.L. c. 176B, § 4K, less any Medicare payments.

_____ Enteral formulas medically necessary for the treatment of inherited diseases of amino acids and organic acids as required by M.G.L. c. 175, § 47I; M.G.L. c. 176A, § 8L; and M.G.L. c. 176B, § 4K, less any Medicare payments. Coverage for inherited disease of amino acids and organic acids shall include food products modified to be low protein in an amount not to exceed $5,000 annually for any Insured individual.

_____ The Medicare daily skilled nursing facility coinsurance for Christian Science Sanatorium nursing services up to 30 days per benefit period.

_____ For those traveling outside the United States, and its territories, coverage for the same services and the same level of payment as is provided within the United States by the combination of Medicare Part A and Part B and the Medicare Supplement 1 Insurance Policy less any Medicare payments.

_____ Where applicable, as required under M.G.L. c. 175, § 47G, as amended from time to time, pap smear tests and mammograms not covered by Medicare.

_____ Non-Medicare covered services rendered by a dentist during a Medicare-eligible admission for those services.

_____ Bone marrow transplants or transplants for certain patients with breast cancer as required by M.G.L. c. 175, § 47M; M.G.L. c. 176A, § 8O (as added by St. 1993, c. 458, § 2); and M.G.L. c. 176B, § 4O not covered by Medicare. The benefit described in 211 CMR 71.90(6) is subject to 211 CMR 71.06(4).

_____ At the option of the Issuer, and if approved by the Commissioner, the New or Innovative Benefits outlined in 211 CMR 71.09(1) or (5). Such New or Innovative Benefits may be offered within the Policy or as an optional Alternate Innovative Benefit Rider to the Medicare Supplement Core Insurance Policy.

_____ Licensed hospice care services to terminally ill patients with a life expectancy of six months or less, as set forth and regulated by M.G.L. c. 111, § 57D and as authorized by a duly licensed physician as required by M.G.L. c. 175, § 47Q (as added by St. 1994, c. 284, § 2); M.G.L. c. 176A, § 8P (as added by St. 1994, c. 284, § 3); and M.G.L. c. 176B, § 4Q (as added by St. 1994, c. 284, § 4).

_____ Expenses incurred in the medically necessary diagnosis and treatment of speech, hearing and language disorders individuals licensed as speech-language pathologists or audiologists under M.G.L. c. 112, as required by M.G.L. c. 175, § 47U (as added by St. 2000, c. 345, § 2); M.G.L. c. 176A, § 8U (as added by St. 2000, c. 345, § 3); and M.G.L. c. 176B, § 4U (as added by St. 2000, c. 345, § 4).

_____ Hormone replacement therapy services for peri and post menopausal women and outpatient contraceptive services under the same terms and conditions as for such other outpatient services. Outpatient contraceptive services shall mean consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of all contraceptive methods to prevent pregnancy that have been approved by the United States Food and Drug Administration, as required by M.G.L. c. 175, § 47W(a) (as added by St. 2002, c. 49, §1); M.G.L. c. 176A, § 8W(a) (as added by St. 2002, c. 49, §2); M.G.L. c. 176B, § 4W(a) (as added by St. 2002, c. 49, §3); and/or M.G.L. c.176G, § 4O(a) (as added by St. 2002, c. 49, § 4). The benefit described in 211 CMR 71.90(12) is subject to 211 CMR 71.06(4).

_____ According to M.G.L. c. 175 §47AA, M.G.L. c. 176A §8DD M.G.L. c. 176B §4DD fully insured health plans **issued or renewed by health insurance carriers on and after January 1, 2011** must provide benefits for the diagnosis and treatment of ASD on a nondiscriminatory basis to all residents of Massachusetts and to all insureds having a principal place of employment in Massachusetts. [refer to above-noted statutes for a complete description of the mandate]

OUTLINE OF COVERAGE 211 CMR 71.13

Applicants and Insureds are to be clearly informed of the basic nature and provisions of Medicare Supplement Insurance Policies through an outline of coverage for each Policy which summarizes its contents. The outline of coverage shall simply and accurately describe benefits provided by Medicare. The outline of coverage shall also accurately describe the Medicare Supplement Insurance Policy benefits along with benefit limitations.

_____ The premium information, disclosures and Massachusetts Summary portions of the outline of coverage shall be in the language and format prescribed below in no less than **12-point type**. Consistent with federal law, as of January 1, 2006, all plans prescribed by 211 CMR 71.90 and 71.91 shall be shown on the cover page, and the plan(s) that are offered by the insurer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective Applicant. All possible premiums for the prospective Applicant shall be illustrated. The outline of coverage including the precise format and language to be used, is set out below in 211 CMR 71.13(2)(c).

The following items shall be included in the outline of coverage in the order prescribed below:

1. Cover Page
2. Text of Outline of Coverage
3. Charts

1. **Cover Page**. [The cover page (c) shall be in the precise format and language set out in 211 CMR 71.98: *Appendix G*]

[Company Name]
Outline of Medicare Supplement Coverage - Cover Page:
Benefit Plans_____[insert names of plans being offered]

Medicare Supplement Insurance can be sold in only two standard plans. This chart shows the benefits included in each plan. Every company must make available the "Core" plan. Companies may add certain benefits to the standard benefits, if approved by the Commissioner. Look at each company's materials to find out what benefits, if any, the company has added to the standard benefits for each plan it offers.

Basic Benefits: Included in All Plans.
Hospitalization: Part A coinsurance coverage for the first 90 days per benefit period (not including the Medicare Part A deductible) and the 60 Medicare lifetime reserve days, plus coverage for 365 additional days after Medicare benefits end. This shall also include benefits for biologically-based mental disorders.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses), or, in the case of hospital outpatient department services paid under a prospective payment system, applicable copayments. This shall also include benefits for biologically-based mental disorders. Blood: First three pints of blood each year.

Core **Standard Benefits**	**Medicare Supplement 1** **Standard Benefits**
Basic Benefits	Basic Benefits
Hospitalization: For biologically based mental disorders, stays in a licensed mental hospital, less Part A deductibles; for other mental disorders: stays in a licensed mental hospital for at least 60 days per calendar year less days covered by Medicare or already covered by plan in that calendar year for the other mental disorders, less Part A deductibles.	Hospitalization: For biologically based mental disorders, stays in a licensed mental hospital; for other mental disorders: stays in a licensed mental hospital for a minimum of 120 days per benefit period (at least 60 days per calendar year) less days covered by Medicare or already covered by plan in that calendar year for the other mental disorders. Skilled Nursing co-insurance Part A deductible Part B deductible Foreign Travel
Additional Benefits [New or Innovative Benefits]	**Additional Benefits** [New or Innovative Benefits]

[Premium Information]	[Premium Information]

2. Text of Outline of Coverage:

_____ MASSACHUSETTS MEDICARE SUPPLEMENT INSURANCE OUTLINE OF COVERAGE
(ISSUER'S NAME)
(Issuer's Policy Name and Number)
Policy Category: MEDICARE SUPPLEMENT INSURANCE
"NOTICE TO BUYER: This Policy may not cover all of the costs associated with medical care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Policy limitations."

_____ **PREMIUM INFORMATION** [Boldface Type]
We [insert Issuer's name] can only raise your premium if we raise the premium for all Policies like yours in Massachusetts, and if approved by the Commissioner of Insurance. If you choose to pay your premium on a quarterly, semiannual, or annual basis, upon your death, we will refund the unearned portion of the premium paid. If you choose to pay your premium on a quarterly, semiannual, or annual basis and you cancel your Policy, we [insert either will or will not] refund the unearned portion of the premium paid. In the case of death [insert if the unearned portion of the premium will be refunded if coverage is canceled: or your cancellation of the Policy] the unearned portion of the premium will be refunded [insert on a pro-rata basis or insert methodology which has been submitted to and approved by the Commissioner].

_____ **DISCLOSURES** [Boldface Type]
Use this outline to compare benefits and premiums among Policies.

_____ **READ YOUR POLICY VERY CAREFULLY** [Boldface Type]
This is only an outline describing your Policy's most important features. The Policy is your
insurance contract. You must read the Policy itself to understand all of the rights and duties of both you and your insurance company.

_____ **RIGHT TO RETURN POLICY** [Boldface Type]
If you find that you are not satisfied with your Policy, you may return it to [insert Issuer's address]. If you send the Policy back to us within 30 days after you receive it, we will treat the Policy as if it had never been issued and return all of your payments.

_____ **POLICY REPLACEMENT** [Boldface Type]
If you are replacing another health insurance Policy, do NOT cancel it until you have actually received your new Policy and are sure you want to keep it. If you cancel your present Policy and then decide that you do not want to keep your new Policy, it may not be possible to get back the coverage of the present Policy.

_____ **NOTICE** [Boldface Type]
This Policy may not fully cover all of your medical costs.
[for agents:]
Neither [insert company's name] nor its agents are connected with Medicare.
[for direct response:]
[insert company' s name] is not connected with Medicare.
This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult “Medicare & You” for more details.

_____ **COMPLETE ANSWERS ARE VERY IMPORTANT** [Boldface Type]

When you fill out the application for the new Policy, be sure to answer truthfully and completely all questions. The company may cancel your Policy and refuse to pay any claims if you leave out or falsify important information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[The term "Certificate" should be substituted for the word "Policy" throughout the outline of coverage where appropriate.]

[The Medicare Supplement outline of coverage shall include the following statement, entitled Massachusetts Summary. The provision concerning "Complaints" must be set forth in a separate paragraph.]

_____ **MASSACHUSETTS SUMMARY** [Boldface Type]

The Commissioner of Insurance has set standards for the sale of Medicare Supplement Insurance Policies. Such Policies help you pay hospital and doctor bills, and some other bills, that are not covered in full by Medicare. Please note that the benefits provided by Medicare and this Medicare Supplement Insurance Policy may not cover all of the costs associated with your treatment. It is important that you become familiar with the benefits provided by Medicare and your Medicare Supplement Insurance Policy. This Policy summary outlines the different coverages you have if, in addition to this Policy, you are also covered by Part A (hospital bills, mainly) and Part B (doctors' bills, mainly) of Medicare.

Under M.G.L. c. 112, § 2, no physician who agrees to treat a Medicare beneficiary may charge to or collect from that beneficiary any amount in excess of the reasonable charge for that service as determined by the United States Secretary of Health and Human Services. This prohibition is commonly referred to as the ban on balance billing. A physician is allowed to charge you or collect from your insurer a copayment or coinsurance for Medicare-covered services. However, if your physician charges you or attempts to collect from you an amount which together with your copayment or coinsurance is greater than the Medicare-approved amount, please contact the Board of Registration in Medicine at [insert the telephone number for the Massachusetts Board of Registration in Medicine regarding licensing].

We cannot explain everything here. Massachusetts law requires that personal insurance Policies be written in easy-to-read language. So, if you have questions about your coverage not answered here, read your Policy. If you still have questions, ask your agent or company. You may also wish to get a copy of “Medicare & You”, a small book put out by Medicare that describes Medicare benefits.

_____ **THE BENEFITS TO PREMIUM RATIO FOR EACH POLICY SOLD is ___%**.

[Insert here the lifetime aggregate anticipated loss ratio from 211 CMR 71.12(10)(a). If the ratio is different for different Policy forms, then separately specify the ratio for each Policy form. Heading should be in Boldface type.]

This means that during the anticipated life of your Policy and others just like it, the company expects to pay out $___ in claims made by you and all other Policyholders for every $100 it collects in premiums. The minimum ratio allowed for Policies of this type is ___%. A higher ratio is to your advantage as long as it allows the company a reasonable return so that the product remains available.

[If the ratio is different for different Policy forms, then provide a separate paragraph for each Policy form.]

_____ **COMPLAINTS** [Boldface type]
If you have a complaint, call us at [area code and telephone number] or your agent. If you are not satisfied, you may write or call the Massachusetts Division of Insurance, [insert the address of the Massachusetts Division of Insurance] or call [insert the telephone number of the consumer helpline at the Massachusetts Division of Insurance].

3. Charts [Insert here a comparison of the benefits available under Medicare A and B, and the Medicare Supplement Insurance Policies in the form prescribed in 211 CMR 71.99: *Appendix G*.

MEDICARE SUPPLEMENT CORE

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general hospital nursing and miscellaneous services and supplies and licensed mental hospital stays for biologically-based mental disorders or other mental disorders prior to the 190-day Medicare lifetime maximum			
First 60 days of a benefit period	All but $[792]	$0	$[792] Part A Deductible
61st through 90th day of a benefit period	All but $[198] a day	$[198] a day	$0
91st day and after of a benefit period:			
- While using 60 lifetime reserve days	All but $[396] a day	$[396] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0
- Beyond the additional 365 days	$0	$0	All Costs
Licensed mental hospital stays not covered by Medicare for biologically-based mental disorders			
First 60 days of a benefit period	$0	All but $[792]	$[792] Part A Deductible
61st through 90th day of a benefit period	$0	100% of Medicare eligible expenses	$0
91st day and after of a benefit period:			
- While using 60 lifetime reserve days	$0	100% of Medicare eligible expenses	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0
- Beyond the additional 365 days	$0	$0	All Costs

MEDICARE SUPPLEMENT CORE

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD (continued)

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Licensed mental hospital stays not covered by Medicare for other mental disorders :			
First 60 days per calendar year less days covered by Medicare or already covered by plan that calendar year for other mental disorders.	$0	All but $[792]	$[792] Part A Deductible
61st day and after of a benefit period	$0	100% of Medicare eligible expenses	$0
- Days after 60 days per calendar year less days covered by Medicare or plan in that calendar year	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
(Participating with Medicare) You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after having left the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[99] a day	$0	Up to $[99] a day
101st day and after	$0	$0	All Costs

MEDICARE SUPPLEMENT CORE

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD (continued)

BLOOD			
First 3 pints	$0	3 Pints	$0
Additional amounts	100%	$0	$0

HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	Coinsurance	$0

NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the Policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE SUPPLEMENT CORE
MEDICARE (PART B) MEDICAL SERVICES - PER CALENDAR YEAR

**Once you have been billed [$100] of Medicare-approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First]$100] of Medicare-approved amounts**	$0	$0	[$100] (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Outpatient treatment for biologically-based mental disorders (for services covered by Medicare)			
First [$100] of Medicare-approved amounts**	$0	$0	[$100] (Part B Deductible)
Remainder of Medicare-approved amounts	50%	50%	$0
Outpatient treatment for biologically-based mental disorders (for services not covered by Medicare)	$0	100% of expenses	$0
Outpatient treatment for other mental health disorders (for services covered by Medicare)			
First [$100] of Medicare-approved amounts**	$0	$0	[$100] (Part B Deductible)
Remainder of Medicare-approved amounts	50%	50%	$0
Outpatient treatment for other mental health disorders (for services not covered by Medicare)			
First 24 visits per calendar year	$0	100%	$0
Visits 25 and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next [$100] of Medicare-approved amounts**	$0	$0	[$100] (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES- BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE SUPPLEMENT CORE

MEDICARE (PART B) MEDICAL SERVICES - PER CALENDAR YEAR (continued)

SPECIAL MANDATED MEDICAL FORMULAS			
Covered by Medicare			
First [$100] of Medicare-approved amounts**	$0	$0	[$100] (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Not covered by Medicare	$0	All allowed charges	Balance

MEDICARE SUPPLEMENT CORE
MEDICARE (PARTS A & B)

**Once you have been billed [$100] of Medicare-approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
Medicare-approved services			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First [$100] of Medicare-approved amounts**	$0	$0	[$100] (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
OUTPATIENT PRESCRIPTION DRUGS NOT COVERED BY MEDICARE	$0	$0	All costs
[ANY NEW OR INNOVATIVE BENEFITS OFFERED BY ISSUER SHALL BE DESCRIBED HERE]			

MEDICARE SUPPLEMENT 1
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general hospital nursing and miscellaneous services and supplies and licensed mental hospital stays for biologically-based mental disorders or other mental disorders prior to the 190-day Medicare lifetime maximum			
First 60 days of a benefit period	All but $[792]	$[792] (Part A Deductible)	$0
61st through 90th day of a benefit period	All but $[198] a day	$[198] a day	$0
91st day and after of a benefit period:			
- While using 60 lifetime reserve days	All but $[396] a day	$[396] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0
- Beyond the additional 365 days	$0	$0	All Costs
Licensed mental hospital stays for biologically-based mental disorders not covered by Medicare			
First 60 days of a benefit period	$0	100% of Medicare eligible expenses	$0
61st through 90th day of a benefit period	$0	100% of Medicare eligible expenses	$0
91st day and after of a benefit period:			
- While using 60 lifetime reserve days	$0	100% of Medicare eligible expenses	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0
- Beyond the additional 365 days	$0	$0	All Costs

MEDICARE SUPPLEMENT 1

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD (continued)

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Licensed mental hospital stays not covered by Medicare for other mental disorders :			
- First 120 days per benefit period (at least 60 days per calendar year) less days covered by Medicare or plan in that calendar year			
First 60 days of a benefit period	$0	100% of Medicare eligible expenses	$0
61st through 120th day of a benefit period	$0	100% of Medicare eligible expenses	$0
- Days after 120 days per benefit period (or 60 days per calendar year) less days covered by Medicare or plan in that calendar year	$0	$0	All Costs

MEDICARE SUPPLEMENT 1
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD (continued)

SKILLED NURSING FACILITY CARE*			
(Participating with Medicare) You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after having left the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[99] a day	Up to $[99] a day	$0
101st day through 365th day of a benefit period	$0	$10 a day	Balance
Beyond the 365th day of a benefit period	$0	$0	All Costs
(Not Participating with Medicare) You must meet Medicare's requirements, including having been in a hospital for at least 3 days and transferred to the facility within 30 days after having left the hospital			
1st day through 365th day of a benefit period	$0	$8 a day	Balance
Beyond the 365th day of a benefit period	$0	$0	All Costs

BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	Coinsurance	$0

NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE SUPPLEMENT 1
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

**Once you have been billed [$100] of Medicare-approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First [$100] of Medicare-approved amounts**	$0	[$100] (Part B Deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Outpatient treatment for biologically-based mental disorders (for services covered by Medicare)			
First [$100] of Medicare-approved amounts**	$0	[$100] (Part B Deductible)	$0
Remainder of Medicare-approved amounts	50%	50%	$0
Outpatient treatment for biologically-based mental disorders (for services not covered by Medicare)	$0	100%	$0
Outpatient treatment for other mental health disorders (for services covered by Medicare)			
First $100 of Medicare-approved amounts**	$0	$100 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	50%	50%	$0
Outpatient treatment for other mental health disorders (for services not covered by Medicare)			
First 24 visits per calendar year	$0	100%	$0
Visits 25 and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare-approved amounts**	$0	$100 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

MEDICARE SUPPLEMENT 1

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR (continued)

CLINICAL LABORATORY SERVICES-			
BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

SPECIAL MEDICAL FORMULAS MANDATED BY LAW			
Covered by Medicare			
First[$100] of Medicare-approved amounts **	$0	[$100] (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Not covered by Medicare	$0	All allowed charges	Balance

MEDICARE SUPPLEMENT 1
MEDICARE PARTS A & B

**Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
Medicare-approved services			
-Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First [$100] of Medicare-approved amounts**	$0	[$100] (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

MEDICARE SUPPLEMENT 1
OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL-NOT COVERED BY MEDICARE			
Only the services listed above while traveling outside the United States	$0	Remainder of charges (including portion normally paid by Medicare)	$0
OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE	$0	$0	All Costs
[ANY NEW OR INNOVATIVE BENEFITS OFFERED BY ISSUER SHALL BE DESCRIBED HERE]			

NOTICE REQUIREMENTS. 211 CMR 71.13(2)(d)

Notice of Changes

As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, every Issuer providing Medicare Supplement Insurance or benefits to a resident of Massachusetts shall notify its Insureds of modifications it has made to its Medicare Supplement Insurance Policies as a result of any changes to the Medicare program or to 211 CMR 71.00. The notice shall be in a format prescribed by the Commissioner.

The notice shall:

Include a separate description of revisions to the Medicare program, if any, and a description of each modification made to the coverage provided under the Medicare Supplement Insurance Policy, as well as how those changes affect the premium, if at all. If there is no change in the premium, the notice must explain why not.

Inform each Insured as to when a premium adjustment, if any, will be made due to changes in Medicare benefits or the Medicare Supplement Insurance Policy

Be in outline form and in clear and simple terms so as to be easy to read

Be clearly labeled and shall not contain or be accompanied in the same mailing by any solicitation or other notices. 211 CMR 71.13(2)(d)(1)d

Please forward copy of a notice that carrier intends to forward in such instances.

Revised Policy Form

No later than 90 days after the date of approval of Medicare Supplement Insurance rates, every Issuer providing Medicare Supplement Insurance, upon satisfying the filing and approval requirements of 211 CMR 71.00, *et seq*. and applicable regulations specifying the procedures for rate hearings on such rate filings, shall provide each Insured with any rider, endorsement or revised Policy form necessary to eliminate any benefit duplication under the Policy with benefits provided by Medicare. Such revision shall not be made by rider or endorsement unless approved by the Commissioner.

Please forward copy of a notice that carrier intends to forward in such instances.

Revised Policy Outline of Coverage

No later than 90 days after the date of approval of Medicare Supplement Insurance rates and in addition to the notice of changes prescribed by 211 CMR 71.13(2)(d)1., every Insured covered by a Medicare Supplement Insurance Policy shall be provided with a revised outline of coverage which reflects any changes made to the Medicare program or to their Medicare Supplement Insurance Policy. Such outline of coverage shall comply with the provisions of 211 CMR 71.13(2)(a), (b) and (c).

Please forward copy of a notice that carrier intends to forward in such instances.

Guide to Health Insurance for People with Medicare

Issuers of accident and sickness Policies which provide hospital or medical expense coverage on an expense incurred or indemnity basis to a person(s) eligible for Medicare

shall provide to those Applicants a *Guide to Health Insurance for People with Medicare* in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration and in a type size no smaller than 12 point type. The *Guide* shall also include an attachment concerning the Massachusetts Medicare Supplement Insurance Program in a form prescribed by the Commissioner in a type size no smaller than 12-point type. Delivery of the *Guide* shall be made whether or not such Policies are advertised, solicited or issued as Medicare Supplement Insurance Policies as defined in 211 CMR 71.00. Except in the case of direct response carriers, delivery of the *Guide* shall be made to the Applicant at the time of application and acknowledgment of receipt of the *Guide* shall be obtained by the insurer. Direct response carriers shall deliver the *Guide* to the Applicant upon request but not later than at the time the Policy is delivered.

Please confirm that the carrier will comply with this requirement.

Required Notice for Non-Medicare Supplement Policies

Any accident and sickness insurance or long-term care insurance policy, other than a Medicare Supplement Insurance Policy, a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. § 1395, *et seq*.); disability income policy or other policy identified in 211 CMR 71.02(2), issued for delivery in Massachusetts to persons eligible for Medicare shall notify Insureds under the policy that the policy is not a Medicare Supplement Insurance Policy. The notice shall either be printed or attached to the first page of the outline of coverage delivered to Insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy delivered to Insureds. The notice shall be in no less than 12 point type and shall contain the following language:

"THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company. "

Please either forward a copy of the described notice or confirm that the notice is printed on the first page of the outline of coverage or the first page of the policy.

Applications provided to persons eligible for Medicare for the health insurance or long-term care insurance policies described in 211 CMR 71.13(2)(d)5.a. shall disclose, using the applicable statement in 211 CMR 71.100 - *Appendix H*, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy.
211 CMR 71.13(2)(d)(5)(b)

Please forward a copy of the notice that the carrier will utilized to comply with this requirement.

APPLICATION FORMS 211 CMR 71.14

Application forms shall include the following questions and statements in precisely the following form designed to elicit information as to whether, as of the date of the application, the Applicant has another Medicare Supplement, Medicare Advantage, Medicaid coverage, or other health insurance policy in force or whether a Medicare Supplement Insurance Policy is intended to replace any other accident and sickness policy presently in force. A supplementary application or other form to be signed by the Applicant and agent containing such questions and statements may be used.

[Statements]

_____ You do not need more than one Medicare Supplement Insurance Policy

_____ If you purchase this Policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

_____ You may be eligible for Medicaid benefits and may not need a Medicare Supplement Insurance Policy.

_____ The benefits and premiums under your Medicare Supplement Insurance Policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your Policy will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement Insurance Policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your Policy was suspended, the reinstituted Policy will not have outpatient prescription drug coverage, as you will be enrolled in the most comparable plan without outpatient prescription drug coverage.
[Issuers that permit a period of suspension for longer than 24 months should delete "for 24 months" and insert the appropriate limitation.]

_____ If you are eligible for, and have enrolled in a Medicare Supplement Insurance Policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement Insurance Policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement Insurance Policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement Insurance Policy (or, if that is no longer available, a substantially equivalent Policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement Insurance Policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your Policy was suspended, the reinstituted Policy will not have outpatient prescription drug coverage, as you will be enrolled in the most comparable plan without outpatient prescription drug coverage.

_____ Counseling services are available in Massachusetts to provide advice concerning your purchase of Medicare Supplement Insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). You may call the Massachusetts Executive Office of Elder Affairs insurance counseling program at [insert the toll-free number of the Massachusetts Executive Office of Elder Affairs] or write to that office at the following address for more information: [insert the address of the Massachusetts Executive Office of Elder Affairs]

_____

[Questions]

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement Insurance Policy, or that you had certain rights to buy such a Policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS.
[Please mark Yes or No below with an "X"]
To the best of your knowledge,
(1) (a) Did you turn age 65 in the last six months?
Yes____ No____
(b) Did you enroll in Medicare Part B in the last six months?
Yes____ No____
(c) If yes, what is the effective date? _____

(2) Are you covered for medical assistance through the state Medicaid program?
[NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.]
Yes____ No____
If yes,
(a) Will Medicaid pay your premiums for this Medicare Supplement Insurance Policy?
Yes____ No____
(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?
Yes____ No____
(3) (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.
START __/__/__ END __/__/__
(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement Insurance Policy?
Yes____ No____
(c) Was this your first time in this type of Medicare plan?

Yes____ No____

(d) Did you drop a Medicare Supplement Insurance Policy to enroll in the Medicare plan?

Yes____ No____

(4) (a) Do you have another Medicare Supplement Insurance Policy in force?

Yes____ No____

(b) If so, with what company, and what plan do you have [optional for Direct Mailers]?

_____

(c) If so, do you intend to replace your current Medicare Supplement Insurance Policy with this policy?

Yes____ No____

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

Yes____ No____

(a) If so, with what company and what kind of policy?

_____

_____

_____

_____

(b) What are your dates of coverage under the other policy?

START __/__/__ END __/__/__

(If you are still covered under the other policy, leave "END" blank.)