MassMutual

Advisor Reference Manual for SignatureCare® 600

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Section 1 – Product Information

SignatureCare 600 Policy Series

SignatureCare 600 Care Insurance can be customized for your clients to meet their unique and changing needs while also helping them to protect their assets, their family and their future.

Advisors may not engage in the solicitation, negotiation or sale of long-term care insurance, unless appropriately licensed, appointed (when required), and having completed the necessary initial and ongoing training requirements (where required), Requirements vary by state. Initial pre-sale training and ongoing training requirements for care insurance can be found on FieldNet LTC SignatureCare 500 Series Page and LTCi & LTCi Partnership Training FN Page

If you have any questions, contact Licensing Support at **1-800-767-1000**, Ext. 48850.2.1

Content provided is for reference purposes only. SignatureCare 600 has been filed through the Interstate Insurance Product Regulation Commission (ICC) and several individual states. The policy details in this manual reflect the ICC approved policy forms for 39 states and those approved by the individual states of CT, DE, HI, IN & ND. The manual does not include information for the following states: AZ, CA, DC, FL, MT, NJ, NY & SD.

Please refer to the ICC or state specific policy for the complete set of definitions and contract provisions. If there is a conflict between this manual and the policy provisions, the policy will govern.

1.1 Product Summary

Policy type		• Comprehensive Daily Reimbursement
Coverage type		• Guaranteed Renewable; coverage continues as long as premiums are paid. Premiums may increase on a class basis subject to regulatory approval.
Issue ages		• 40 – 69 (age nearest birthday)
Elimination periods		• 90 service days
Benefit periods		• 2-Year, 3-Year, 4-Year, 5-Year, 6-Year
Daily Benefit Amount (DBA)		• Purchased in increments of $10, $100 minimum required in most states, and subject to a maximum of $400 which includes any other long-term care coverage in force at time of Application. • Facility and Home and Community Based Services, when covered under the Policy, are reimbursed at 100% of actual charges up to the selected Daily Benefit Amount.
Underwriting classes		• Ultra Preferred • Select Preferred • Preferred
Rate structure		• Sex-distinct rates for all states except Montana
Dividends		• Participating Policy: while the Policy is in force, We may credit dividends. Dividends are not guaranteed. For more information, see the Dividends section under Policy Features (Section1.3)
Spousal discount		• 15% permanent discount for individuals who are married, domestic partners or part of a civil union (subject to state regulation)
Policy benefits		• Facility Services Benefit • Facility Bed Reservation Benefit • Home and Community Based Services Benefit • Live at Home Benefit • Respite Care Benefit • Care Coordination Benefit • Waiver of Premium
Riders (available at additional cost)	Riders available to everyone:	• Compound Inflation Protection Rider (3% or 5% options) • Home and Community Based Services Monthly Benefit Rider • Home and Community Based Services Waiver of Elimination • Period Rider • Shortened Benefit Period Nonforfeiture Rider
	Riders available only to Covered Partners:	• Waiver of Premium for Covered Partner Rider • Paid-Up Survivor Benefit Rider
Payment structure		• Premium is paid for the life of the Policy

1.2 Policy Information

SignatureCare 600 is a participating long-term care insurance product that provides a pool of benefits (Total Benefit Amount) to reimburse Covered Expenses for Qualified Long-Term Care Services received in a Facility or through a Home- and Community-Based Service, up to a specified Daily Benefit Amount.

The Total Benefit Amount is equal to 365 multiplied by the selected Daily Benefit Amount, multiplied by the selected benefit period (in years). Unless stated otherwise in the Policy, all benefits paid are subtracted from the Total Benefit Amount, with the remaining balance available for future benefits.

For example, if a client elects a daily benefit of $200 per day and a benefit period of six years, then the pool of benefits is $438,000 ($200/day x 365 days/year x 6 years). If Covered Expenses are incurred at $200 a day, the pool of benefits will last six years. However, if only a portion of the daily benefit is used, the balance will remain available for future services, and may extend the benefit period Well beyond six years.

A second pool of benefits, the Total Live at Home Benefit Amount, is accessible without needing to satisfy the Elimination Period, providing the Insured is eligible for benefits in accordance with the Live at Home Benefit. The maximum reimbursement under this benefit is equal to the selected Daily Benefit Amount multiplied by 60.

Facility Services Benefits

We will provide reimbursement for Covered Expenses incurred for the receipt of Qualified Long-Term Care Services provided to the Insured while Confined in a Nursing Facility, Assisted Living Facility, or Hospice Facility. Expenses mean the actual daily cost of each day's Facility Services up to the Daily Benefit Amount.

Facility Bed Reservation Benefit

Reimburses Covered Expenses, up to a daily maximum equal to the Daily Benefit Amount, when the Insured incurs charges to reserve a bed in a Nursing Facility or an Assisted Living Facility should the Insured be absent for any reason. The maximum amount payable per Policy Year is 60 times the Daily Benefit Amount.

Home- and Community-Based Services

Reimbursement, up to the Daily Benefit Amount for the actual cost of Adult Day Care received at an Adult Day Care Center or Home Health Care or Hospice Care received at home, is provided under the HCBS Benefit. The HCBS Benefit is not payable for any day on which the Insured receives Facility Services or is Confined in a Hospital.

Live at Home Benefit

We will provide a benefit equal to the Covered Expenses for Live at Home Services including, but not limited to, Emergency Response System Services, Ambulance Services, Caregiver Training, Home Modification, and Durable Medical Equipment. There must be agreement between the Insured/their Representative, the Insured's Licensed Health Care Practitioner and Us that these Live at Home Services are cost effective, appropriate to the Insured's needs and are eligible Qualified Long-Term Care Services.

The cost for these services cannot exceed the remaining Total Live at Home Benefit Amount. Any unused amount under this benefit may be used to provide benefits that would otherwise reduce the Total Benefit Amount in the event that benefit has been exhausted. The Elimination Period is not required to be satisfied for this benefit. Receipt of the Live at Home Benefit does not count toward the satisfaction of the Elimination Period.

Respite Care Benefit

We will provide reimbursement for the actual cost, up to 30 times the Daily Benefit Amount per Policy Year, for each day Qualified Long-Term Care Services are provided to the Insured on a short term basis to relieve an Informal Caregiver in the Insured's residence, a Nursing Facility, Assisted Living Facility, or through a community-based program. The Elimination Period is not required to be satisfied for this benefit. Receipt of the Respite Care Benefit does not count toward satisfaction of the Elimination Period. Once the Elimination Period has been satisfied, any claims for Respite Care Benefits will be classified as either Facility Services Benefits or Home and Community Based Services Benefits, as applicable, and the Waiver of Premium provisions will apply.

Care Coordination Benefit

The Insured is entitled to the assistance of a Care Coordinator. The Insured, his/her Representative, or a Family Member may contact Our claim office and request Care Coordination at any time during an active claim to initiate the process of having a Care Coordinator assigned to the Insured. A Care Coordinator is a Licensed Health Care Practitioner that will assess the Insureds needs, develop and make updates to a Plan of Care, and coordinate and monitor delivery of appropriate services. Use of a Care Coordinator is voluntary. The use or non-use of a Care Coordinator does not impact the right to other benefits under this Policy. If the Insured chooses to utilize the services of a Care Coordinator, the costs of the Care Coordination Services will be billed to and paid by Us directly. The Elimination Period is not required to be satisfied for this benefit. Use of the Care Coordination Benefit does not count toward satisfaction of the Elimination Period.

Pre-Existing Conditions Limitation

None

Limitations and Exclusions

No Benefits will be paid and the Elimination Period will not be satisfied for any Confinement, care, treatment, or service(s):

- provided to the Insured by a Family Member.
- provided Outside of the United States.
- provided for the treatment of alcoholism or drug addiction.
- for which you or the Insured have no financial liability or that is provided at no charge in the absence of insurance.
- while engaged in an illegal occupation.
- due to participation in a felony, riot or insurrection.
- which results from a declared or undeclared war or act of war.
- due to attempted suicide, or
- due to any intentionally self-inflicted injury.

Non-Duplication of Benefits

Benefits are not payable under the Policy for expenses incurred to the extent that such expenses are reimbursable under, or would be so reimbursable but for the Application of a deductible or co-insurance amount; or for any other state or federal worker's compensation plan or other governmental program (except Medicaid).

For purposes of satisfying the Elimination Period, days on which the Insured is eligible for benefits, but coverage is excluded due to the Non-Duplication of Benefits provision, will count toward satisfaction of the Elimination Period.

Waiver of Premium

Once the Elimination Period has been satisfied, We will waive premium payments while We are paying benefits for Facility Services, HCBS, or Facility bed reservation. This waiver applies to the entire premium for the Policy (including all riders attached to the Policy). If premiums have been paid for a period for which premiums have been waived, such premiums will be refunded on a pro-rata basis. Such pro-rata refunds will be used to reduce future premiums, if any, or if not so used, will be refunded under the Refund of Unearned Premium provision. This waiver ceases and premiums become due when We are no longer paying benefits for Facility Services, HCBS, or Facility bed reservation.

Policy Ownership

The Insured is the Owner of the Policy unless otherwise provided in the Application or changed by Written Request. If the Insured is not the Owner and the Owner dies while the Insured is living, unless otherwise provided, Ownership will be transferred to the Owner's executor or administrators. If the Owner is someone other than the Insured, the Supplemental Application for Policy Ownership must be completed and submitted with the Application.

Optional Riders

Compound Inflation Protection Rider

SignatureCare offers a Compound Inflation Protection Rider with 3% or 5% options. The rider increases the Policy's Daily Benefit Amount, unused Total Benefit Amount, and unused Total Live at Home Benefit Amount on each Policy Anniversary Date for the life of the Policy, even while the Insured is receiving benefits.

HCBS Waiver of the Elimination Period Rider

This rider permits the payment of benefits for HCBS received on days used to satisfy the Policy's Elimination Period. Days for which an HCBS benefit is paid under this rider are credited toward the satisfaction of the Elimination Period for other benefits under the Policy.

HCBS Monthly Benefit Rider

The HCBS Monthly Benefit Rider changes the HCBS daily reimbursement to a monthly reimbursement. The Monthly Benefit Amount for a given calendar month is equal to the Daily Benefit Amount times thirty-one, less any Facility Services benefits received during that calendar month. One way this rider can provide more flexibility is when scheduling Home Health Care services. Sometimes specialists such as physical therapists do not come to the Home on Weekends. Or perhaps Family Members are providing care on Weekends. In either situation, there may be a need for more care on some days, which could easily exceed the daily benefit.

For example, the client selects a Daily Benefit Amount of $100; daily reimbursement will pay 100% of actual charges up to the daily benefit of $100 for Qualified Long-Term Care Services. When the HCBS Monthly Benefit Rider is added, We will reimburse the Insured up to $3,100 per month (Daily Benefit Amount times 31). This allows the Insured more flexibility in scheduling services during the month. He/she can schedule multiple Home Health Care services in one day, subject to the Plan of Care. However, in this example, benefits paid will never be greater than $3,100 per calendar month.

Shortened Benefit Period Nonforfeiture Rider

This rider allows the Policyowner to retain limited coverage if the Policy lapses due to non-payment of premium after being In Force for at least three years. Should this occur, the Policy will become paid up with modified coverage based on the Daily Benefit Amount immediately in effect on the date of the lapse. The sum of the Total Benefit Amount and Total Live at Home Benefit Amount's remaining benefits available will become equal to the greater of: (a) the total of premiums paid for the Policy and all riders; or (b) thirty times the Daily Benefit Amount in effect on the date of lapse. These benefits will first be allocated to the Total Live at Home Benefit Amount, up to the Total Live at Home Benefit Amount in effect on the date of lapse. The remaining balance, if any, will be allocated to the Total Benefit Amount up to the Total Benefit Amount in effect on the date of lapse.

Paid-Up Survivor Benefit Rider

The Paid-Up Survivor Benefit Rider allows a Policy and all attached riders to be paid up, with no further premium due after **both** of the following have occurred:

- the death of the Covered Partner, and
- the 10th Policy Anniversary Date

If the Covered Partner dies before the 10th Policy Anniversary Date, the premium for the survivor's Policy and rider must continue to be paid until the 10th Policy Anniversary Date, unless waived under the Policy at which point the Policy will be paid up and no further premium payments will be required.

A Paid-Up Survivor Benefit Rider must be issued with and remain attached to the Covered Partner's Policy. Both the Policy, including this rider and the Covered Partner's Policy, including this rider must remain In Force, or the rider will terminate.

The cost of the rider varies by Issue-Age and a different first-year commission applies. Check FieldNet for state-specific compensation schedules.

Waiver of Premium for Covered Partner Rider

This rider will waive the premium payments for the Policy to which the rider is attached during any period in which the premium payments for the Covered Partner's Policy are waived. A Waiver of Premium for Covered Partner Rider must be issued with and remain attached to the Covered Partner's Policy. Both the Policy including this rider and the Covered Partner's Policy including this rider must remain In Force, or the rider will terminate.

Contingent Benefit Upon Lapse Endorsement (CBUL)

The CBUL Endorsement is attached to Policies issued without the Shortened Benefit Period Nonforfeiture Rider. This endorsement will provide a contingent benefit in the event that the insurer makes a substantial increase to the premium rates and the Policy lapses within 120 days of the due date of the increased premium. The benefit will allow for a choice between (1) reducing coverage, subject to benefit availability, so that premiums do not increase or (2) the Policy being converted to a paid-up status and benefits available will be adjusted as described for the Shortened Benefit Period Nonforfeiture Rider.

1.3 Dividends

Because MassMutual's long-term care insurance is a participating product, a Policy may be credited with dividends. Due to the tax-qualified nature of these Policies, any dividends credited to the Policy will first be used to reduce future premiums. If the dividend exceeds the premium due, any dividend remaining after payment of premiums will be used to increase the future benefits of this Policy in an amount equal to the remaining dividend. Additional benefits provided by dividend will be used to pay any claim covered by the Policy before reducing any benefits otherwise available under the Policy.

Dividends are not guaranteed.

1.4 Partnership Programs

Long-term care Partnership programs were developed in the 1980s to encourage people who might otherwise turn to Medicaid to finance their long-term care, by purchasing long-term care insurance (LTCi). Generally under a federal Partnership program, when determining an individual's eligibility for Medicaid, the state will disregard a portion of the individual's assets equal to the amount of insurance benefits received under a Partnership Policy.

Once a state enacts and implements an LTC Partnership program, Partnership Policies in the state will be required to meet specific criteria, including federal tax qualification, identified consumer protections, and inflation protection provisions. In addition, states must require individuals who sell an LTCi Policy under the Partnership to receive LTCi education/training. Please refer to FieldNet for state availability. LTCi & LTCi Partnership Training FN Page and Pre-Sale Training & Ongoing Training Requirements for LTC.

Questions and Answers about Partnership

Q: Does my state have a Partnership Program and is MassMutual® offering Partnership at this time?

A: MassMutual offers Partnership Qualified Policies in most federal Partnership programs. We do not offer Partnership Qualified Policies in state Partnership Programs (California, Connecticut, Indiana and New York) or in the MassHealth Program in Massachusetts. See FieldNet for a complete list of states where Partnership qualified Policies are offered. LTCi & LTCi Partnership Training FN Page and Pre-Sale Training & Ongoing Training Requirements for LTC.

Q: What's the difference between a Partnership qualified Policy and other long-term care insurance Policies?

A: The difference is that Partnership Policies must satisfy age-based annual inflation protection requirements and the Policy must be issued in the state where the Insured resides.

Federal Partnership Policies are required to include annual inflation protection that complies with the following:

- For a person who is less than 61 years of age as of the date of purchase of the Policy, the Policy shall provide compound inflation protection.
- For a person who is at least 61 years of age but less than 69 years of age as of the date of purchase of the Policy, the Policy shall provide simple or compound inflation protection.

NOTE: The inflation protection requirements may vary by state.

Q: How does Medicaid asset protection work?

A: Partnership Policyowners who apply for Medicaid coverage are able to maintain assets, equal to the amount of LTC insurance benefit paid, above the Medicaid asset limit currently in place for eligibility purposes.

Q: Is there a minimum daily benefit requirement for Partnership Policies?

A: Federal Partnership programs offered by MassMutual do not have minimum daily benefit requirements.

Q: Is there an additional cost for a Partnership qualified Policy?

A: There is no additional charge for Partnership classification. Partnership Policies are priced the same as non-Partnership Policies that have the same Policy features and riders.

Q: Is a Partnership qualified Policy appropriate for my client?

A: Though this is a question you need to consider on an individual basis for each client, the chances are that Partnership is appropriate for many of your clients. Remember that there is no additional cost for Partnership as long as the appropriate inflation protection rider is already selected. MassMutual recommends that you discuss the potential benefits of selecting a Partnership Policy with each of your clients seeking long-term care insurance.

Q: Will my client be able to recognize the difference between a Partnership Policy and a traditional long-term care Policy?

A: An applicant will receive a copy of the Acknowledgement Regarding Partnership Policy Qualification Form at the time of Application which explains that if applicant has selected the Inflation Protection Rider, he/she will be issued a Partnership policy and that if that rider is not selected the policy, if approved, will be a non-Partnership policy. Otherwise there is no difference in appearance or content except that the Partnership Policy is issued with a "Partnership Status Disclosure Notice."

Q: Will existing Policyowners be "grandfathered" into the Partnership program? What is Partnership Exchange?

A: No, Policies are not "grandfathered" into the Partnership program. Many states that are implementing an LTCi Partnership program include an "exchange requirement." In these states, insurers that offer LTCi Policies will be required to allow certain LTCi Policyowners the ability to exchange a previously purchased non-Partnership LTCi Policy for an LTCi Partnership Policy.

MassMutual will implement an exchange program for all eligible policyowners in accordance with the applicable state mandate within twelve months of launching Partnership qualified Policies in the state. You and your client will be notified if the client is eligible for a Partnership exchange. In most states, qualifying non-Partnership Policies will be automatically exchanged for a new Partnership qualified Policy unless the client elects not to take part in the exchange offer.

Q: What happens if a Policyowner moves to another state after purchasing a Partnership Policy?

A: Partnership and non-Partnership Policyowners may receive benefits from their SignatureCare 600 Policies anywhere in the United States, based on the terms of the Policies they select. Benefits received under a Partnership Policy can accumulate Medicaid asset protection, even if a Policyowner is in another state.

A Partnership Policyowner who applies for Medicaid in a state other than the state where the Policy was purchased may be eligible for Medicaid asset protection in that state. Eligibility will depend on whether the state in which the Policy was purchased has Medicaid asset protection reciprocity with the other state at the time the Policyowner applies to that state's Medicaid program. Many states have entered into a national reciprocity agreement; however, states may opt out of reciprocity at any time with 30 days' notice.

Q: If a Policyowner exhausts his/her LTCi Partnership Policy benefits, will he/she be automatically qualified for Medicaid benefits?

A: No, Long-Term Care Partnership Policyowners must meet the state-mandated income and asset requirements in order to be eligible for Medicaid benefits.

Questions and Answers about LTCi & LTCi Partnership Training Requirements

Q: Do I need to satisfy any special requirements in order to sell Partnership Policies?

A: Financial professionals must have appropriate state licenses and must complete state training requirements prior to selling, soliciting, or negotiating any LTCi Policies, including Partnership. In most states, additional Partnership-specific training is also required in order to sell LTCi, regardless of whether you are selling a Partnership Policy or not. See FieldNet for further details about the training required in your state. LTCi & LTCi Partnership Training FN Page and Pre-Sale Training & Ongoing Training Requirements for LTC.

Q: If I complete the training requirement in my home state, will it satisfy the requirement for other states?

A: In some cases, the training you take in your home state will satisfy the training requirement for another state in which you are licensed to sell long-term care insurance.

However, some states require that a separate training course or a supplemental course be taken in order to satisfy their requirement. See FieldNet for further details about the training required to sell in a particular state. LTCi & LTCi Partnership Training FN Page and Pre-Sale Training & Ongoing Training Requirements for LTC.

Q: If I completed the non-resident training requirement in another state, will I need to complete additional training if my home state implements a training requirement?

A: As stated in the previous question, it depends on the state requirement. See FieldNet for further details about the training required to sell in a particular state. LTCi & LTCi Partnership Training FN Page.

Q: Once I complete the initial training requirement, are there any Continuing Education requirements?

A: Yes, most states require a 4 hour continuing education course every 24 months. See FieldNet for further details about the training required in your state. LTCi & LTCi Partnership Training FN Page and Pre-Sale Training & Ongoing Training Requirements for LTC.

Q: Where on FieldNet can I find further details about state training requirements?

A: LTCi & LTCi Partnership Training FN Page.

Q: Where do I submit a copy of my certificate once I have completed my training?

A: You should submit a copy of your completion certificate to the licensing contact in your agency. Your licensing contact will in turn forward your certificate to MassMutual's licensing department for processing. For questions, contact Licensing Support at **1-800-767-1000, Ext. 48850**.

Q: Who can I contact if I have questions about long-term care training requirements?

A: Contact Licensing Support at **1-800-767-1000, Ext. 48850**.

1.5 Premium Payment

Premiums are paid for life of the Policy. SignatureCare 600 is guaranteed renewable, that is, coverage will continue as long as premiums are paid. Premiums may be changed on a class basis and may increase subject to regulatory approval.

1.6 Premium Frequency and Options

Important Statement About Premium Payment Frequency (read carefully)

A MassMutual Policyowner has the right to choose among four premium payment frequency options. Each payment option, other than annual, has an additional cost. The additional cost varies depending upon the type of Policy and its original issue date. Premium frequencies are outlined in the Policy illustration.

The Policyowner may pay premiums once a year (annually), twice a year (semiannually), four times a year (quarterly) or twelve times a year (monthly).

There may be other premium payment options available on certain products. Please contact MassMutual at **1-888-505-8952** for more information.

How to Change the Premium Payment Frequency

The client has the right to change the frequency of premium payments during the lifetime of the Policy. In order to make a change, notify the MassMutual, Long-Term Care Administrative Office at 21600 Oxnard Street, Suite 1500, Woodland Hills, CA 91367) or **www.ltcMassMutual.com**.

A client may also contact a MassMutual Customer Service Representative at **1-888-505-8952**.

1.7 Discounts

Spousal Discount

A 15% permanent discount is available to Insureds who are married, in a domestic Partnership (subject to state regulation), or part of a civil union (subject to state regulation).

1. 8 Definitions

Definitions may vary by state. Please refer to **www.ltcMassMutual.com** for state-specific contracts and contract definitions.

Activities of Daily Living:

- **Bathing** means washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
- **Continence** means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- **Dressing** means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- **Eating** means feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
- **Toileting** means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- **Transferring** means moving into or out of a bed, chair, or wheelchair.

Adult Day Care means a program for six (6) or more individuals (or a fewer number of persons as required by applicable state law or regulation) of social or health-related services, or both, provided during the day in a community group setting for the purpose of supporting frail, impaired, elderly, or other disabled adults who can benefit from care in a group setting outside the Home.

Adult Day Care Center means a Facility that provides Adult Day Care to adults who do not require twenty-four (24) hour institutional care, but who are not capable of full-time, independent living; and has the appropriate state licensure or certification as an Adult Day Care Center. If licensure or certification is not required, it meets **all** of the following criteria:

- provides Adult Day Care for only part of a day to persons living at Home,
- has enough full-time staff to maintain no greater than an 8:1 client to staff ratio, and
- has established procedures for obtaining appropriate aid in the event of a medical emergency.

Ambulance Services means transportation of the Insured by ambulance to or from a Hospital or Facility.

Ancillary Services means physical, occupational, speech and respiratory therapies, wound care, medication management, supplies and services for continence care, and similar care-related services or supplies that support Activities of Daily Living.

Application(s) means the written Application form provided by Us and completed by you and the Insured, if different, when applying for coverage or applying for reinstatement of lapsed coverage.

Assisted Living Facility means a Facility, or a wing, ward, or unit of a Facility, including secure Alzheimer's units, which is engaged primarily in providing Qualified Long-Term Care Services and has the appropriate state licensure or certification as an Assisted Living Facility where licensure or certification is required. If licensure or certification is not required, it meets **all** of the following criteria:

- provides Qualified Long-Term Care Services for at least six (6) residents in one (1) location,
- has at least one (1) trained and ready-to-respond staff member actively on duty in the Facility twenty-four (24) hours per day to provide the services and care,
- provides room and board to include at least three (3) meals a day and accommodation of special dietary need,
- has appropriate procedures to dispense and monitor prescription medications, and
- maintains records of important health changes in its residents.

An Assisted Living Facility is not a Hospital; a Nursing Facility; the Insured's Home; or the Home of a Family Member; a Facility for the treatment of alcoholism, alcohol abuse, or drug addiction; or a Facility operated primarily for the treatment of Mental or Nervous Disorders.

Care Coordinator means a Licensed Health Care Practitioner who is qualified by training and experience to assess and coordinate the overall care needs of a Chronically Ill individual. The Care Coordinator is not employed by or under contract to Us. The Care Coordinator is employed by or under contract to a Care Coordination Services Provider.

Care Coordination Services means a process by which the Insured's functional, cognitive, personal, and social care needs are identified and potentially linked to a full range of appropriate services. This includes the following:

- performance of comprehensive individualized assessments.
- development of an initial Plan of Care.
- updates to the Plan of Care for changes in the Insured's condition and when transitioning off of claim.
- coordination of appropriate services and ongoing monitoring of such services.

Care Coordination Services Provider means an agency, entity, or person approved by Us that employs or contracts with Care Coordinators to provide Care Coordination Services.

Caregiver Training means training provided by a health care professional, approved by Us, to an Informal Caregiver. Examples of such training may include, but are not limited to:

- the proper care and use of medical devices such as catheters, intravenous medications, colostomy bags, or suctioning tubes.
- the proper assistance with medications, bandages, and dressings.
- the proper performance of various procedures to assist the Insured with Activities of Daily Living.

Chronically Ill means that within the previous twelve (12) months a Licensed Health Care Practitioner has certified that the Insured:

- is unable to perform, without Substantial Assistance from another person, at least two (2) Activities of Daily Living for a period that is expected to last at least ninety (90) consecutive days due to loss of functional capacity, or
- has a Severe Cognitive Impairment.

Confinement or Confined means the Insured is a resident in a Facility, for a period for which a room and board charge is made.

Covered Expenses means the amount of benefits payable by Us as a result of the Insured's receipt of Qualified Long-Term Care Services. The Covered Expense for each benefit available under this Policy is further defined in the Benefit Provisions of this Policy.

Covered Partner means the Insured's spouse or Partner who is covered by Us under a Policy with the same state Policy form number as this Policy.

Daily Benefit Amount means the maximum amount of benefits that may be paid under the Policy on a daily basis. The initial Daily Benefit Amount is shown on the Policy Schedule. The current Daily Benefit Amount is the initial Daily Benefit Amount adjusted to reflect the provisions of any inflation protection rider attached to this Policy.

Durable Medical Equipment means equipment included in the Insured's Plan of Care which:

- is functionally necessary.
- is designed for repeated and prolonged use.
- is suited for use in the Home.
- can enhance the Insured's ability to perform Activities of Daily Living.

Infusion pumps, special hospital-style beds, walkers, or wheelchairs are examples of types of equipment that may be considered Durable Medical Equipment. Durable Medical Equipment does not include any Home Modification, motorized scooter, or sporting, athletic or exercise equipment, prosthetic devices, or dentures.

Elimination Period means the number of days the Insured must receive either Facility Services or Home and Community Based Services, as defined in this Policy, before We will begin paying benefits. These services must be received, while the Policy is In Force, while the Insured is certified as being Chronically Ill, and in accordance with a Plan of Care. We will credit one (1) day toward satisfaction of the Elimination Period for each day the Insured receives Facility Services.

We will credit seven (7) days toward satisfaction of the Elimination Period for each calendar Week (Sunday through Saturday) provided the Insured receives Home and Community Based Services on at least one (1) day during the calendar Week.

In no event will We credit more than seven (7) days toward satisfaction of the Elimination Period for any calendar Week. Days credited toward satisfaction of the Elimination Period may be accumulated under separate claims. Once the Insured has satisfied the Elimination Period, no further Elimination Period is required.

The Elimination Period is not applicable to or satisfied by the Live at Home Benefit, the Respite Care Benefit or the Care Coordination Benefit.

The Elimination Period is shown on the Policy Schedule.

Emergency Response System Services means a personal service the Insured can alert easily (such as pressing a button on a bracelet or pendant) when in distress and in need of help. This does not include a home alarm security system.

Facility means a Nursing Facility, Assisted Living Facility, or Hospice Facility.

Facility Services means Qualified Long-Term Care Services received by the Insured while confined in a Facility, including:

- a room and board.
- Ancillary Services.
- Ambulance Services.
- Hospice Care provided in a Hospice Facility.

Facility Services does not include comfort and convenience items such as televisions, telephone, beauty care, and entertainment, or services provided to an individual other than the Insured (e.g., guest meals or spouse charges).

Family Member means the Insured's spouse (or Partner) and the following relatives by blood, marriage, or adoption, of the Insured or the Insured's spouse (or Partner):

- grandparents,
- parents, aunts, uncles,
- siblings, first cousins,
- children, nieces, nephews, and
- grandchildren.

Hands-On Assistance means the physical assistance of another person without which the Insured would be unable to perform any one or more of the Activities of Daily Living.

Home means the place where the Insured maintains independent residence. Home does not include a Facility, a Hospital, or any other institutional setting where the Insured is dependent on others for Substantial Assistance with the Activities of Daily Living or Substantial Supervision due to a Severe Cognitive Impairment.

Home and Community Based Services means:

- Adult Day Care provided to a Chronically Ill Insured in an Adult Day Care Center.
- Home Health Care provided to a Chronically Ill Insured at Home.
- Hospice Care provided to a Chronically Ill Insured at Home.

Home Health Aide means a person, other than Nurse, who provides Qualified Long-Term Care Services through a Home Health Care Agency or as an Independent Home Health Caregiver.

Home Health Care means Qualified Long-Term Care Services provided to a Chronically Ill individual, in their Home and pursuant to a Plan of Care, including:

- professional nursing care by or under the supervision of a Nurse.
- care provided by a Home Health Care Agency.
- care provided by a Home Health Aide.
- therapeutic care services by or under the supervision of a speech, occupational, physical, or respiratory therapist licensed or certified under state law if any, or a registered dietician.
- Homemaker Services.
- Substantial Supervision that is required due to Severe Cognitive Impairment.

Home Health Care Agency means an entity that is regularly engaged in providing Home Health Care for compensation and employs staff, qualified by training or experience, to provide such care. The entity must:

- keep clinical records or care plans on all patients,
- provide ongoing supervision and training to its employees appropriate to the services to be provided, and
- have the appropriate state licensure or certification, where required.

If licensure or certification is not required, the entity must be supervised by a qualified professional such as a Registered Nurse (RN), a Licensed Social Worker, or a Physician, and must meet the above criteria.

Home Modification means the labor, equipment, and supplies used to make changes in the Insured's Home. These changes must be designed to:

- assist the Insured in performing Activities of Daily Living.
- allow the Insured to live safely and remain at Home.

Examples of Home Modifications include: installation of ramps for wheelchair access, installation of shower bars, widening of doorways, and other similar accessibility modifications. Home Modification does not include: elevators, escalators, hot tubs, spa or whirlpool-type tubs, swimming pools, garage door openers, Home repair or maintenance, or other modifications that may, other than incidentally, increase the value of the Insured's Home. Nor does Home Modification include the costs of any building permits or inspections.

Homemaker Services means those services provided by a Home Health Care Agency or an Independent Home Health Caregiver that specializes in maintaining cleanliness and hygiene of the internal portions of the Insured's Home. Services may include cleaning, vacuuming, and laundering. Additional services may include purchase and provision of food, as Well as transportation to receive care from medical professionals or obtain prescription medications. Homemaker Services must be provided during the same visit and by the same individual providing Substantial Assistance in the Activities of Daily Living or Substantial Supervision for a Severe Cognitive Impairment.

Hospice Care means Qualified Long-Term Care Services that provide a program of care to meet the Insured's needs at Home or in a Hospice Facility in the event the Insured becomes terminally ill. Terminally ill means there is no reasonable prospect of cure and the Insured has a life expectancy, as estimated by a Physician, of six (6) months or less.

Hospice Facility means a place that:

- has the appropriate federal certification as a Hospice Facility or is state licensed, certified, or registered where required, and
- provides Hospice Care.

Hospital means an institution or Facility that is:

- licensed as a Hospital by the proper authority of the state in which it is located, or
- accredited as a Hospital by the Joint Commission on Accreditation of Hospitals.

In Force means that the Policy has not terminated in accordance with the Policy termination provision.

Independent Home Health Caregiver means an independently employed individual not associated with a Home Health Care Agency and approved by Us who has the appropriate state licensure or certification as a Registered Nurse (RN), occupational, speech, physical, or respiratory therapist, social worker, dietician, Home Health Aide, or Certified Nurse Aide. If licensure or certification is either not required or not attained, the individual must **meet** the following criteria:

- submit written employment verification to Us certifying employment within the past five (5) years as a Nurse aide at a Hospital, Nursing Facility, Assisted Living Facility, or Home Health Care Agency within a minimum of twelve (12) months of employment, or
- submit written proof to Us of completion of an established training course within the past five (5) years with a minimum of seventy-five (75) hours of in-class training and sixteen (16) hours of clinical training, and including the following components: bathing, dressing, safe transferring and lifting techniques, personal hygiene, basic nutrition, infection protection and control, managing incontinence, psychosocial and emotional support, and safety monitoring for those with Severe Cognitive Impairment.

An Independent Home Health Caregiver may not be a Family Member, must be at least eighteen (18) years of age or older, must submit a valid government-issued form of identification, and must also provide Us with fee documentation that includes the date, nature, and charges for all covered care the Insured receives. We may require that the care be periodically monitored by a Licensed Health Care Practitioner at Our cost.

Informal Caregiver means the person who has the primary responsibility for providing non-professional care on an unpaid basis for the Insured at Home. A person who is paid for caring for the Insured cannot be an Informal Caregiver.

Insured means the person who is insured under this Policy and is named on the Policy schedule.

Issue Age means the age of the Insured on the birthday nearest the Policy Effective Date; it is shown on the Policy schedule page.

- **Example:** Elizabeth's 56th birthday was May 12. The Policy Effective Date is December 1. Since December 1 is closer to her 57th birthday, her Issue-Age will be 57.

Licensed Health Care Practitioner means:

- a Physician, or
- a Registered Nurse, or
- a Licensed Social Worker, or
- another individual who meets requirements prescribed by the U.S. Secretary of the Treasury.

The Licensed Health Care Practitioner must not be a Family Member.

Licensed Social Worker means a duly licensed social worker acting within the scope of his or her license at the time Qualified Long-Term Care Services are provided.

Live at Home Services means Qualified Long-Term Care Services, including:

- Emergency Response System Services.
- Ambulance Services.
- Caregiver Training.
- Home Modification.
- Durable Medical Equipment, provided the Insured meets the requirements for Eligibility for the Payment of Benefits and is not Confined in a Facility.

Maintenance or Personal Care Services means any care for which the primary purpose is to help the Insured conduct Activities of Daily Living while Chronically Ill. This includes protection from threats to the Insured's health and safety due to a Severe Cognitive Impairment.

Medicaid means the reimbursement system under Title XIX of the Federal Social Security Act, as amended.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

Mental or Nervous Disorder means affective disorders, anxiety disorders, personality disorders, psychotic disorders, or other mental or emotional disease or disorders. Mental or Nervous Disorder does not include Alzheimer's or other demonstrable organic diseases such as senile dementia.

Nurse means someone who is licensed as a Registered Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN), and is operating within the scope of that license.

Nursing Facility means a Facility, institution, or a wing, ward, or unit of a Facility, including secure Alzheimer's units, which provides nursing care to inpatients and has the appropriate state licensure or certification as a Nursing Facility where licensure or certification is required. If licensure or certification is not required, it meets **all** of the following criteria:

- is a separate Facility or a distinct part of another health care Facility,
- provides twenty-four (24) hour per day of skilled, intermediate or custodial nursing care under the supervision of a Registered Nurse (RN) or Physician, and
- maintains a daily record on each patient.

A Nursing Facility is not: a Hospital, clinic, or Assisted Living Facility; a convalescent home; a board and rest home; a home for the aged; an adult residential care Facility; a domiciliary and retirement care Facility; a training center; a government or veteran's Facility; the Insured's Home; a Facility for the treatment of alcoholism, alcohol abuse, or drug addiction, or a Facility operated primarily for the treatment of Mental or Nervous Disorders.

Outside of the United States means outside of the United States and its territories.

Owner means the Owner of this Policy as indicated in Our records. The Owner is the Insured unless otherwise provided in the Application or changed by Written Request.

Partner means a civil union partner or domestic partner as defined under applicable state law.

Physician, as defined in section 1861(r)(1) of the Social Security Act, means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she performs such function or action, including osteopathic practitioners within the scope of his or her practice as defined by state law.

Plan of Care means a written individualized plan of services prescribed by a Licensed Health Care Practitioner for a Chronically Ill Insured developed in consultation with the Insured or the Insured's Representative. The Plan of Care will specify the type, frequency, and providers of the services most suitable to meet the Insured's long-term care needs and the costs, if any, of those services. The Plan of Care is subject to change as the Insured's condition and service requirements change and must be updated as the Insured's needs change.

Policy means this legal contract between you and Us.

Policy Anniversary Date(s) means the Policy Anniversary Date as shown on the Policy Schedule. The first Policy Anniversary Date is one (1) year after the Policy Effective Date.

Policy Effective Date means the date that coverage under this Policy and any attached riders as shown on the Policy schedule take effect, provided that the Policy has been issued and delivered, the initial premium has been received, and outstanding delivery requirements, if any, have been received in good order.

Policy Year means each annual period for which coverage is In Force. The first Policy Year begins on the Policy Effective Date and ends on the last calendar day before the first Policy Anniversary Date. Subsequent Policy Years begin on subsequent Policy Anniversary Dates.

Premium Payor means the person or entity making the premium payments for this Policy as indicated in Our records.

Qualified Long-Term Care Services means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and Maintenance or Personal Care Services, which are required by the Insured when Chronically Ill, and are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Registered Nurse (RN) means a duly licensed, registered graduate professional nurse acting within the scope of his or her license at the time the treatment or service is performed.

Representative means a person or entity legally empowered to represent another.

Respite Care means Qualified Long-Term Care Services provided to the Insured on a short term basis to relieve an Informal Caregiver in the Insured's residence. Respite Care may be provided in the Insured's Home, a Nursing Facility, an Assisted Living Facility or through a community-based program.

Severe Cognitive Impairment means the deterioration or loss of cognitive capacity which requires Substantial Supervision. Severe Cognitive Impairment is measured by clinical evidence and standardized tests that reliably measure a person's impairment in:

- short or long-term memory.
- orientation as to person (such as the person's identity), place (such as the person's location) and time (such as day, date and year).
- deductive or abstract reasoning.
- judgement as it relates to safety awareness.

An example of Severe Cognitive Impairment would be Alzheimer's disease and similar forms of irreversible dementia which require Substantial Supervision.

Stand-By Assistance means the presence of another person within arm's reach of the Insured that is necessary to prevent, by physical intervention, injury to the Insured while performing an Activity of Daily Living.

Substantial Assistance means Hands-On Assistance or Stand-By Assistance.

Substantial Supervision means continual supervision by another person to protect a person with a Severe Cognitive Impairment or others from threats to health or safety (such as may result from wandering). Such supervision may include cueing by verbal prompting, gestures, or other similar demonstrations.

Total Benefit Amount means the maximum amount of benefits that may be paid under this Policy, not including the Live at Home Benefit, Care Coordination Benefit, and any additional benefit as a result of crediting of dividends. The initial Total Benefit Amount is shown on the Policy Schedule. The Total Benefit Amount after Policy issue will be decreased by all benefits paid under this Policy, except the Live at Home Benefit, Care Coordination Benefit, and additional benefits resulting from the crediting of dividends. The Total Benefit Amount after Policy issue will be increased in accordance with the provisions of any riders attached to this Policy.

Total Live at Home Benefit Amount means the maximum amount of Live at Home Benefits that may be paid under this Policy. The initial Total Live at Home Benefit Amount is shown on the Policy schedule. The Total Live at Home Benefit Amount after Policy issue will be decreased by all Live at Home Benefits paid under the Policy. The Total Live at Home Benefit Amount after Policy issue will be increased in accordance with the applicable provisions of any riders attached to this Policy.

We, Us, Our means Massachusetts Mutual Life Insurance Company.

Written Request means a request in writing, satisfactory to Us, received by Us at Our LTC Administrative Office. In the future, We may also allow the telephone, internet, or other electronic media to be used for certain transactions that currently require a Written Request. We will accept such requests only after the appropriate Policies, procedures, and security measures have been established.

You, your means the Owner of this Policy.

Section 2 – General Information, Administration, and Resources

2.1 Contacts for SignatureCare

Pre-sale support from the National Sales Desk at the home office.

Call **1-800-767-1000, Ext. 22222**: Monday through Thursday, 8 a.m. to 6 p.m. ET, and Friday, 8 a.m. to 5 p.m. ET. The role of the National Sales Desk is to support the sales force with pre-sale questions, including the following:

- clarification/interpretation of Policy features and provisions.
- product information.
- taxation.
- marketing materials.
- illustration assistance.
- product comparison information.
- seminar advice.
- FieldNet assistance.
- solution assistance (product design assistance).
- applications and forms.

New Business, Policy Administration, and Claim process support from the Long-Term Care Administrative Office

The role of the long-term care administrative office is to provide administrative support services, ranging from new business Application processing, underwriting, Policy administration and claims for SignatureCare policies only, life-hybrid products and riders are processed at the home office. The long-term care administrative office toll-free number is **1-888-505-8952**, **option 1**, available Monday through Friday, 8 a.m. to 8 p.m. ET, to assist with the following:

- Pre-qualification process
- eApp including eSignature
- Pending Application Status
- Post-issue (i.e., policy delivery requirements and policy reissues)
- Inforce Policies (i.e., Premium payment options, billing, lapse and reinstatements, policy benefit changes, etc.)

- Claims process

2.2 Long-Term Care Administration Website

Before submitting business, you must set up access to the long-term care administrative website. Go to **www.ltcMassMutual.com** , click on the link "Need a User Name and Password" next click on the link "Fill out the Request for Web Site Access," and complete the requested information and you will receive a user name and temporary password.

2.3 Credentialing Licenses, Appointments, and Educational Requirements

General Information

Advisors may not engage in the solicitation, negotiation e or sale of long-term care insurance, unless appropriately licensed, appointed (when required), and having completed the necessary initial and ongoing training requirements (where required), Requirements vary by state. Initial pre-sale training and ongoing training requirements for care insurance can be found on FieldNet LTCi & LTCi Partnership Training FN Page.

If you have any questions, contact Licensing Support at **1-800-767-1000**, **Ext. 48850.2.1.**

State license and applicable presale training requirements must be current prior to selling, soliciting, or negotiating long-term care insurance.

All Advisors involved in the sale **MUST** be licensed in the state where the Application is signed.

- soliciting advisors on LTC business must be state insurance licensed and appointed with MassMutual.
- non-soliciting advisors, (a.k.a. compensation recipients), must be state insurance licensed to sell LTC business, but are not required to be appointed with MassMutual.

For more information about credentialing refer to FieldNet Credentialing FN Page or Contact Licensing Support at **1-800-767-1000**, **Ext. 48850.2.1.**

Risk Located States

Risk located states require advisors to be licensed in the state of the Insured's residence, in addition to the state where the Application will be signed, if different. Please refer to Credentialing FN Page or LTCi & LTCi Partnership Training FN Page for more information.

2.4 Submitting New Business

At Time of Application

NOTE: State variations may require the use of additional or different forms.

Refer to **www.ltcMassMutual.com** or the Application Instruction form (MM600xx) to select the correct Application and other state-required forms.

The Application should match the Insured's state of residence and dictates the correct state Application forms to use as well as other state-related disclosures.

Survey Applications are not available for SignatureCare.

The following items **MUST** be delivered to the proposed applicant and/or proposed Owner at the time of Application:

- Outline of Coverage (Disclosure Form in some states),
- "Things You Should Know Before You Buy Care Insurance",
- Potential Rate Increase Disclosure Form,
- HIPAA Authorization for the Release of Personal Health-Related Information,
- Company's HIPAA Privacy Notice,
- Disclosure Notice – Medical Information Bureau and Fair Credit Reporting,
- Replacement form must be used if replacing existing coverage,
- State specific forms or disclosures, if applicable,
- Conditional Premium Receipt,
- The NAIC Shopper's Guide to Long Term Care Insurance (or similar if state requires), and
- Important Notice to Persons on Medicare.

The following items **MUST** be submitted with the Application:

- completed and signed LTC Personal Worksheet,
- signed HIPAA Authorization for the Release of Personal Health-Related Information, and
- signed Replacement form if replacing existing coverage.
- completed and signed Conditional Premium Receipt with the initial premium

NOTE: Required Benefit Rejection section of the Application must be completed.

Ways to Complete and Submit an Application

Paperless E-App & E-Signature

Follow these steps to complete and submit E-App with E-Signature:

1. Run an illustration in E-App
2. Complete E-app
3. Enter the payment info
4. Client and advisor E-Sign
5. Submit case
6. Submit Initial Premium

E-App with Wet Signature

Follow these steps to complete and submit E-App with wet signature:

1. Run an illustration in E-App
2. Complete E-App
3. Print forms and collect wet signatures
4. Enter the payment info
5. Image paper application and client check payment, if applicable
6. Attach images to E-App case
7. Submit case
8. Submit Initial Premium

Document Upload

Follow these steps to upload a completed application:

1. Run an illustration in E-App
2. Download a fillable application packet via ltcMassMutual.com
3. Print forms & collect wet signatures
4. Image paper application packet and client check payment, if applicable
5. Upload all documents
6. Submit case
7. Submit Initial Premium

Additional information is available on the FieldNet LTC New Business page LTCi New Business Page.

Illustrations

The SignatureCare sales illustration software can be accessed from FieldNet/New Sales/ Illustrations & Proposals or from **www.ltcMassMutual.com**. User name and password is required.

SignatureCare requires a copy of the illustration to be submitted with the Application. **NOTE: When presenting the sales illustration to your client, the Cover Page and Outline of Coverage must accompany all illustrations.**

Contact the National Sales Desk for assistance with accessing and/or running illustrations at **1-800-767-1000, Ext. 22222**.

Contract State and Application Requirements

The Insured's state of residence dictates the correct state Application forms to use as Well as other state-related disclosures.

Residence Guidelines

In order to apply for SignatureCare, the Insured **MUST** meet the following criteria:

- be a U.S. resident with a permanent address in the United States. We will not accept a post office box as a residence address, and
- have a U.S. Social Security number or Tax ID. This is used for 1099-LTC tax reporting of LTCi benefits paid on qualified Policies.

Foreign Residence

Any client planning to reside outside the U.S. for an extended period of time should not apply for SignatureCare 600, since benefits are payable for services in the U.S. only.

Non-U.S. Citizens Living Full-Time in the U.S.

Any client who is not a U.S. citizen, but is living full-time in the U.S., will be considered if they **MEET** the following criteria:

- must have a U.S. Social Security number or Tax ID,
- must reside in the U.S. with a permanent residence and address (P.O. Box not acceptable),
- must have an established health care provider in U.S., and
- must plan to remain in the U.S. because no benefits are payable under the applied-for Policy for Covered Services received by the proposed Applicant outside of the U.S., and the Elimination Period will not be satisfied for any Confinement, care, treatment, or services that are provided Outside of the U.S.

Collection of the Initial Premium Payment

For all proposed applicants, two (2) months initial premium is the minimum required and must be submitted with the application unless restricted by state, e.g. California and New Hampshire require only one (1) month initial premium. The Conditional Premium Receipt form (form #ICC17MMCRT) must be completed.

- The initial premium payment can be paid by paper check. All initial premium checks must be made payable to Massachusetts Mutual Life Insurance Company.
- If the mode is other than monthly, up to one (1) full modal premium is required.
- If the mode is monthly, minimum two (2) months initial premium is required, except California or New Hampshire require one (1) month.
- We do not accept deposits, agency/advisor checks or post-dated checks.

Balance of Premium

- If at time of issue, it is determined that additional premium is required, the balance due must be received with the delivery requirements in the LTC Administrative Office before commissions are paid.

  Paper check only. At this time, we do not draft any balance of premium due or accept credit card payments.

Premium Renewal Billing

The Premium Payer must provide a U.S. billing address and must make premium payments in U.S. funds.

Replacements

In some situations, the MassMutual applicant has decided to replace coverage in-force with another company. This should be decided only after fully discussing and considering the advantages and disadvantages of that particular replacement and must comply with replacement requirements for long-term care insurance. Any replacement recommendation should be in the best interest of the client and appropriate, e.g. the new policy must provide increased benefits and/or lower premiums for similar benefits. Document the specific reason for recommending the replacement in your client file.

The appropriate state version of the replacement form must be completed and submitted with the application.

Replacements defined:

- Has an existing in-force long-term care insurance, medical or health insurance coverage or certificate in force with another company that the applicant will not keep if the SignatureCare policy is issued.
- Has an existing in-force SignatureCare policy, MassMutual hybrid or long-term care rider and is applying for a new SignatureCare policy.
- This includes any situation in which a new SignatureCare long-term care policy is issued under a new policy number and the original SignatureCare long-term care policy becomes lapsed.
- Had existing long-term care insurance, medical or health insurance coverage or certificate in force during 12 months prior to applying for SignatureCare and that existing insurance coverage or certificate lapsed within 65 days prior to the new SignatureCare application signed date.

Commission Limitations for Replacements

Commissions will be paid in accordance with any applicable state regulations. There are currently 10 states (AL, CA, DE, IN, KY, NC, NY, PA, SD and WI) that specific rules regarding replacements. For more details, refer to FieldNet Compensation/Commission FN Page.

1035 Exchanges

We will accept 1035 Exchanges of annuities or life Policies from a surrendering company for a SignatureCare Care insurance Policy. Refer to LTC6407 Pension Protection Act 1035 Exchanges and other LTC Insurance Solution for more information. LTC6407 PPA and 1035s Brochure.

Policy Dating

Policy Effective Date

Unless otherwise requested, the underwriting approval date will be the Policy Effective Date.

Backdating

Backdating should be done to save age (including maximum issue age), SignatureCare will allow up to 60 days from the original Application signature date. Use the cover letter or the Special Request section of the Application to make this request.

Postdating or Advance Dating

The Policy Effective Date can be postdated up to 60 days in advance of the underwriting approval date. Use the cover letter or Special Request section of the Application to make this request.

Helpful Reminders

- SignatureCare uses an "age nearest birthday" Issue Age, meaning that the Proposed Applicant's Issue Age will be changed if the updated Policy Effective Date is more than six months after their most recent birthday.
- If there is an age change, additional premium will be needed.
- Effective dates cannot be the 29th, 30th, or 31st, and will automatically be updated to the first of the following month.

Suitability

MassMutual complies with the NAIC provisions on suitability for SignatureCare, regardless of whether or not the state mandates suitability requirements. In summary, these provisions require us to develop and use suitability standards to assure that the purchase or replacement of LTC insurance is appropriate for the needs of the applicant. Suitability for this standalone LTC insurance product focuses on minimum standards regarding affordability of the ongoing premium and availability of public assistance (Medicaid). Appropriateness of the sale is based upon the individual's financial situation, goals, and needs with respect to long-term care.

Long-Term Care Insurance Personal Worksheet

The Long-Term Care Insurance Personal Worksheet must be completed and submitted with the Application. The completion of this worksheet identifies the cost of the coverage, establishes a relationship between this cost and the Owner's income and assets and outlines that the Policy is guaranteed renewable with rates that may be subject to increase in the future.

The worksheet will explain the suitability guidelines and process. The company will review all completed personal worksheets.

If you have questions about suitability guidelines for this product or completing the Personal Worksheet, refer to the state-specific Application Instructions, look under Guidelines for Suitability Standards for LTC Insurance, or contact the National Sales Desk at the home office, **1-800-767-1000, Ext. 22222**.

Prequalify Your Client and Save Time

SignatureCare makes it easy for you to contact the underwriting department for prequalification:

- complete LTC6404 SignatureCare Long-Term Care Insurance Pre-Qualifying Checklist and Underwriting Guidelines — Will Your Client Qualify,
- email underwriting at **status@ltcMassMutual.com**. and attach the Application,
- when the Underwriting Department responds to call the Underwriting department phone number **1-888-505-8952**, press **option 1**, then ask to be transferred to an underwriter during normal business hours.

2.5 Underwriting Process

Snap Shot of Requirements

Requirement	Ages 40–63	Ages 64–69
Medical records	YES	YES
Telephone Interview (Non-Cognitive)	YES	NO
Telephone Interview (with Cognitive screen)	NO	YES
Underwriting Assessment (face-to-face)	Infrequent and at underwriter's request	
Paramedical Exam	Infrequent and at underwriter's request	
Medication record	YES	YES
Motor Vehicle Report	Infrequent and at underwriter's request	

SignatureCare Underwriting Approach and Process

Long-Term Care underwriting does not modify the coverage applied for or apply any additional ratings. We make every attempt to issue the benefits applied for and at the best published rate class premiums.

Providing complete and accurate information on the Application for insurance is essential to a timely underwriting decision. All questions are important and any unanswered question(s) may cause processing delay.

Establish Realistic Expectations

Be sure that your client understands the long-term care underwriting process and knows what to expect. Provide your client with LTC6403, *Taking the first step toward a more secure future – The Long-Term Care Insurance Underwriting Process* LTC6403 LTC UW Process an informative brochure outlining the underwriting process. On average, it takes 35 business days to complete the underwriting process.

Pharmacy Database Check (a.k.a. the Medication Report)

This report provides information about prescription drug history and is ordered and received by underwriting.

Medical Records

Reduce the underwriting cycle time and save five to seven business days on average by ordering medical records from the primary doctor only. Advisors/agency staff may order the required medical records from our approved vendors Attending Physician Statements FN Page or directly from the physician or medical Facility. For agency-ordered medical records, please provide a cover letter with the Application to avoid duplication of requests. If the advisor or the agency pre-paid or there is a payment required, email a copy of the cancelled check or other proof of payment and invoice to **status@ltcMassMutual.com** for prompt processing.

Otherwise, the underwriting department will order the medical records.

Generally, we do not have any difficulties obtaining medical records. The vendor usually contacts the Facility daily until confirmation of our request is received. Thereafter, a status call is made every three business days to ensure timely receipt of the medical records; based on the Facility or copy service procedures, they may ask the vendor to call less frequently. At times, We may ask for your assistance to get a special authorization signed.

Telephone Interview

The telephone interview helps to confirm the information on the Application. Also, for age 64 and older, a cognitive screen (memory test) is completed too. The interview typically takes twenty (20) minutes to complete but may vary depending on the client's medical history. Let us know in a cover letter if special accommodations are needed, e.g., hearing impaired or an interpreter is needed for a non-English-speaking client.

Best Time to Call

Within two business days of receiving the Application, We will attempt the telephone health interview. Please indicate the best time to call and a telephone number in the Applicant Information section of the Application. We do not schedule appointments, so if the interviewer calls at an inconvenient time, it is important for the client to request a call back at a more convenient time.

Underwriting Assessment (also known as the Face-to-Face Interview)

The underwriter will notify you in advance if an underwriting assessment is needed. The assessment includes questions related to health history, general activity level, and functional ability regarding both instrumental and activities of daily living. Physical observations, mobility and cognitive screening are included as well. This usually takes 45 minutes to complete and conducted in the proposed applicant's home.

Paramedical Exam

This is a personal interview conducted in the home to include medical history, height, weight, blood pressure, pulse rate, and blood and urine and may be needed for one of the following reasons:

- currently being treated for a chronic medical condition and has not followed up with their medical professional within the last 2 years,
- no primary care physician, or
- for cause; based on additional finding(s) developed during the underwriting process.

The underwriter will notify you in advance if a paramedical exam is needed.

Rate Class Guidelines

Refer to the Field Underwriting Guide located on FieldNet to help determine the appropriate rate class Field Underwriting Guide and set client expectations.

SignatureCare offers three premium rate classes that you may quote: Ultra Preferred, Select Preferred and Preferred.

Rate Classifications

Ultra Preferred (For clients who are in excellent health, nonsmokers, and with normal weight to height ratio.)

- "No" answer to the tobacco/smoker/ nicotine product (includes nicotine gum, e-cigarettes, etc.) in last 12 months question on the Application.
- Height and Weight within the ultra-preferred range stated in the build chart (refer to the Build section of field underwriting guide)
- Stable medical history/health condition without evidence of complications that satisfy Ultra Preferred criteria outlined in the field underwriting guide.
- Independent in all Activities of Daily Living.
- Regular routine follow-up with a Physician, including physicals.
- Regular follow up with a physician.

Select Preferred (For clients who are generally in good health but may be under treatment but considered well controlled. This rate class is for smokers too.)

- A "yes" answer to the tobacco/nicotine product (including nicotine gum, etc.) in last 12 months question on the Application.
- Height and Weight within the Select Preferred range stated in the build chart (see Build section of field underwriting guide).
- Stable medical history/health conditions without evidence of complications that satisfy Select Preferred criteria outlined in the field underwriting guide.
- Independence in all Activities of Daily Living.
- Regular follow up with a Physician.

Preferred (For clients with multiple medical impairments that are considered controlled with treatment e.g. medication.)

- A "yes" answer to the tobacco/nicotine product (including nicotine gum, etc.) in last 12 months question on the Application.
- Height and weight that does not exceed Preferred guidelines in the build chart (see Build section of Field Underwriting Guide).
- Stable medical history/health conditions without evidence of complications that satisfy the Preferred criteria in the field underwriting guide.
- Independence in all Activities of Daily Living.
- Regular follow-up with a physician.

Closing the File at Day 90

Pending Applications will be closed (Incompleted) 90 days from the Application Received Date if the necessary underwriting requirements have not been received. The initial premium submitted with the Application will be refunded directly to the client. If the outstanding requirements are received after the file has been closed, We will contact you to determine next steps.

Adverse Underwriting Decisions and the Why letter

Adverse underwriting decisions are defined as decisions to rate, modify, or decline coverage. All clients will receive a letter explaining the outcome of underwriting. Upon request, the "Why" letter will be sent to the client stating the specific reason(s) for the adverse underwriting decision.

Appeal of an Underwriting Decision

Clients may appeal a decision if they feel it was based on outdated or incorrect medical information. Please follow the process:

- Request the "Why" letter which will provide the specific reason(s) for the decision.
- Submit a letter to underwriting from the Physician explaining any discrepancies or concerns along with supporting information e.g., lab test, x-ray, etc.
- Important to note that the Physician must provide objective information, such as test results or other clinical findings, rather than opinions or testimonials.
- Send the appeal letter with appropriate supportive information directly to the underwriting department (email to **status@ltcMassMutual.com**).

Requests for Lab Results or Copies of Certain Underwriting Information to be Sent to a Client

Form MM 0304 — Access Request Form must be signed by the client and forwarded to the LTC Administrative Office for processing (**status@ltcMassMutual.com**).

Rate Class Reconsiderations

At times, Policies modified and issued other than as applied for can be re-evaluated at some time in the future if new medical information is available for Our review. Requests for reconsideration of an original underwriting rate class, including a change to non-smoker rates, can be initiated with a quick call to Our agency service department to begin the process. The agency service Representative will contact the underwriting department to review the request on a preliminary basis and determine what, if any, underwriting requirements needed. If underwriting agrees the change request can be considered, you will be provided with the proper forms and requirements necessary to proceed.

2.6 Policy-Related Procedures

Administrative/Status Website: www.ltcMassMutual.com.

Once submitted, Application status and outstanding requirements are available to view via the Website address above. Please allow processing time up to three business days to check the status of new Applications. The Website contains real-time updates of current status. Or, call Agent Services at **1-888-505-8952**, **option 1**.

Turnaround Time

It may take up to 35 business days to process Applications (from submit date to underwriter final decision date depending upon complexity).

Policy Issue and Delivery Guidelines

Policies are mailed directly to the agency for delivery. Before a Policy is reported and commissions paid, all delivery requirements **MUST** be submitted to the LTC Administrative Office.

- Delivery requirements will be indicated on the Delivery Transmittal. The Policy must be delivered within 30 days from the mailing date. There are no exceptions.
- Obtain and submit any delivery requirements including the Policy delivery receipt to the LTC Administrative Office (fax and email is accepted).

Reissues

Reissues will be considered based on the status of the Policy as described below:

- Pending delivery or during the Free-Look Period, return the Policy with a Written Request for reissue and submit a revised illustration.
- After Free-Look Period and Within 90 days of the initial Policy mail date to make a change, contact the underwriter to determine if the change will require any additional underwriting requirements e.g., a new Application. Return the Policy with a written request for reissue, a new Application (if required), additional premium if applicable, and a sales illustration reflecting the changes.
- You have 30 days from the mailing date of the Reissued Policy to deliver the new Policy and obtain any outstanding delivery requirements, including the Policy delivery receipt.
- More than 90 days from the initial Policy mail date, the Policy cannot be reissued. Submit a new Application with a check for the appropriate amount and sales illustration indicating the coverage desired. In these cases a Replacement Form is required, and additional information may be required to ensure health status has not changed.

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