

# Your 2009 Benefits Guide

for Agents



We'll help you get there.™

# Your 2009 Benefits Guide



**DISCLAIMER:** This booklet contains an overview of various MassMutual plans and policies that may apply to eligible career agents of MassMutual effective January 1 of each plan year. In the event of any difference between these descriptions and an actual plan or policy, the plan document or policy shall prevail.

This booklet is not an Employee Retirement Income Security Act (ERISA) Summary Plan Description (SPD). Eligibility for any MassMutual benefit is subject to the provisions of the plan document and administrative policies relating to that benefit.

MassMutual reserves the right to modify, revoke, change, suspend or terminate any one or all plans, programs, policies, benefits or services described in this booklet or the underlying plan documents at any time and from time to time, with or without notice.

Receipt of this material does not imply your eligibility for any one or all of the plans and programs described. Deductibles, copayments, plan provisions and calendar-year maximums are current as of the November 2008 publication date and are subject to change. All information described in this booklet is effective January 1, 2009 and all references to time are Eastern Time (ET) unless specified otherwise.

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# MassMutual Benefits: A Partnership

Each year, MassMutual spends a significant amount of money providing career agents with benefits that are competitive for the financial services industry. In 2008, for example, we expect to incur approximately \$160 million in benefit expenses.

A large component of these expenses is health costs. As health costs continue to rise, it's more important than ever for self-insured plans like MassMutual to offer benefits that provide the most value for the money. That's important not just for MassMutual's bottom line, but for your wallet as well – because both you and the Company share in the cost of benefits. In fact, MassMutual pays approximately two-thirds of the cost of agents' health care, and agents pay the rest. We estimate that the Company will spend an average of approximately \$7,222 per agent\* on medical and dental expenses in 2008.

MassMutual takes many steps to control benefit costs and remain competitive, including:

- Reviewing health benefits each year
- Benchmarking with our competitors every other year
- Enhancing preventive care and medical management benefits to encourage healthy behavior

You can help control your own health care costs by maintaining or working toward better health, and using the health care system wisely. To help you make your own health- and benefit-related decisions, MassMutual provides timely benefits information and decision-making tools along the way.

*MassMutual pays approximately two-thirds of the cost of an agent's health care, and the agent pays the rest.*

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\*This number is the average for all agent health expenses in aggregate (including covered dependents).

# Eligibility

MassMutual is able to provide certain benefits to its independently contracted sales agents. Financed career contract agents become eligible and remain eligible for health and welfare\* (H&W) benefits as long as they continue to satisfy their annual financing requirements. Non-financed career agents generally must satisfy specific weighted commission credit (WCC) production requirements each year to remain eligible for subsidized H&W benefits the following year.

These requirements, updated from time to time, are published in a Company memorandum distributed to all agents and available on FieldNet. Agents who do not meet minimum production requirements may still be eligible for some H&W benefits on an unsubsidized basis.

Unsubsidized agents are not eligible for FSAs or pre-tax HSA deductions.

You can also cover your eligible spouse or domestic partner and eligible dependent children under medical, dental, vision and dependent life insurance.

## Dependent Eligibility (for Medical, Dental, Vision and Dependent Life Insurance)

### Who's eligible:

- **Your spouse, or**
- **Your domestic partner (DP)**

*Notes regarding DPs:* You may enroll a qualifying DP of the same or opposite sex. To qualify, you and your DP must sign and submit an Affidavit of Domestic Partnership, part of the “Domestic Partnership Kit” available on My Benefits under Forms, attesting to all of the following:

- You are each other’s sole domestic partner and intend to be so indefinitely

- You reside together as if married and intend to continue to do so indefinitely
- You have lived together as domestic partners for at least 12 consecutive months prior to enrollment
- You are both at least 18 years old
- You share financial responsibilities and expenses
- You and your domestic partner are not legally married to anyone
- You are not related any closer than would make your marriage illegal

*Tax implications for DPs:* Because of IRS rules, the full, unsubsidized cost of your domestic partner’s health coverage (including medical, dental and vision) will be included as taxable income to you. You pay federal and state income taxes, and Social Security withholding based on the unsubsidized value of the coverage (called “imputed value”). There are some exceptions; see the “Domestic Partnership Kit” for details.

- **Your (or your domestic partner’s) child(ren), foster child(ren) or those for whom you are legal guardian** through age 18 (through age 24 if full-time student at an accredited institution) if they are:
  - tax code dependents,
  - not working full time,
  - not married, and
  - not active members of the armed forces.

Certain exceptions apply for disabled dependents over the age limits noted here. See the Summary Plan Description (SPD) on My Benefits for details.

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\*Health and welfare benefits include medical, dental, vision, flexible spending accounts, group term life insurance and short- and long-term disability.

## Eligible Dependent Checklist

### Who is an eligible dependent?

Provided they are not active members of the armed forces, eligible dependents include:

### What you need to know or do to cover a dependent:

#### Your opposite-sex spouse (for medical, dental, vision and dependent life insurance)

Your opposite-sex spouse is a person of the opposite sex to whom you are legally married.

- You must certify that you are legally married by clicking the check box while you're enrolling in your benefits in Producer Center (see benefit enrollment instructions).

#### Your same-sex spouse (for medical, dental, vision and dependent life insurance)

Your same-sex spouse is a person of the same sex with whom you have a legally recognized marriage.

- Notify MassMutual Benefits that you are covering your same-sex spouse by e-mailing [BenefitQuestions@MassMutual.com](mailto:BenefitQuestions@MassMutual.com) or calling 866-662-6448.

#### Your Domestic Partner (for medical, dental, vision and dependent life insurance)

A domestic partner is a person of the same or opposite sex who has lived with you in a marital-type relationship for at least 12 consecutive months prior to enrolling in the plan.

- Sign and submit MassMutual's affidavit of domestic partnership.  
Download the form from FieldNet > My Practice > Benefits > My Benefits > Forms > Benefit Forms > Domestic Partner Kit.

#### Your Dependent Child(ren) (for medical, dental, vision, and dependent life)\*

This includes:

- Child(ren) for whom you are the legal guardian
- Child(ren) for whom the court has issued a Qualified Medical Child Support Order (QMCSO)
- Child(ren) of same sex marriage
- Child(ren) placed in your home for adoption
- Foster child(ren)
- Legally adopted child(ren)
- Stepchild(ren)
- Your domestic partner's child(ren) if your domestic partner is covered under the plan

Note: Expenses under the FSAs qualify as eligible only if the child is your dependent for tax purposes.

#### For child(ren) younger than age 19:

- Child's principal residence must be the same as your residence for six or more months of the Plan year, unless you have a QMCSO,
- You must have provided at least one-half of the child's financial support for the Plan year,
- You must claim the child as a dependent for federal income tax purposes, and
- Child cannot be married or working full time.

#### For child(ren) older than age 18 and younger than age 25:

- Child must be a full-time student at an accredited educational institution,
- You must claim the child as a dependent for federal income tax purposes,
- Child cannot be married, working full time, or a member of the armed forces, and
- Child must have the same address as the plan member. A full-time student's principal residence is deemed to be his/her parent's address, even if living on or off campus.

#### For child(ren) older than age 18 who are totally incapacitated and incapable of self-support:

- The physician must submit supporting documentation to the medical carrier for approval. The carrier will advise you of your dependent's status.

**Upon initial enrollment, contact MassMutual Benefits at Ext. 46169 or 866-662-6448 prior to logging on to the enrollment portal to allow your dependent child(ren) between the ages of 19 and 25 to be set up as an eligible dependent.**

\*Eligibility for health-care and dependent care FSA expenses vary from the information above. Please see IRS Publications 502 and 503 ([www.irs.gov/publications/p502](http://www.irs.gov/publications/p502) and [www.irs.gov/publications/p503](http://www.irs.gov/publications/p503)) for more information.

#### Notes:

- By enrolling in your benefits online, you certify that the dependents you are adding to your plan meet the guidelines outlined above.
- Initially, new hires do not need to provide documentation to prove eligibility. If necessary, eligibility verification will be requested once you choose your medical, dental, vision or dependent life insurance options. After that, annual dependent verification may be requested if your child is between the ages of 19 and 24.
- MassMutual plans do not provide ex-spouse coverage.

## Costs

The burning question on most people's minds is, "How much will my benefits cost?" The cost of your benefits is two-fold: How much you contribute toward the cost of your benefits each commission voucher, and how much you pay out-of-pocket for deductibles, copayments or coinsurance throughout the year.

**To find your per-commission-voucher benefit costs:** Go to Producer Center from FieldNet, My Practice, Benefits and select the *Benefits* tab. During enrollment, select the appropriate enrollment event and view your Worksheet to see all the benefit options for which you are eligible and all the costs. Also, for your convenience, per-commission-voucher costs for medical coverage are listed on the Medical Comparison Chart. And, dental and vision care costs are listed on those charts within this guide.

**While we're on the subject of costs:** Your benefit deductions are pre-tax,\* with the exception of dependent life insurance. You may choose to purchase long-term disability (LTD 70) coverage post-tax if you wish (see "Disability" on page 21 for more information).

## Levels of Coverage

You may choose among four levels of coverage for most benefit options:

- Individual (yourself alone)
- Individual and spouse or domestic partner (two adults)
- Individual and child(ren) (one adult and one or more children)
- Family (two adults and one or more children)

## Health Plan Options

MassMutual's health and welfare benefit options are offered "cafeteria" style. This means you can pick and choose among benefits and levels of coverage independently of each other. For example, you could choose medical coverage for yourself and your eligible dependents and dental coverage only for yourself.

## Medical

MassMutual offers several different medical options, as follows:

### In-Network-Only Options (often referred to as HMOs or EPOs)

*Key features:*

- Only providers within the particular medical option network are covered (except in an emergency). If you do not use network providers, you may pay the full cost for services you receive.
- Office visits are covered 100% after a \$15 (primary care physician) or \$30 (specialist) copay. Some exceptions: Urgent care center visits require a \$50 copay.
- Advanced radiology and out-patient surgery require a \$100 copay; emergency room visits require a \$150 copay; and inpatient hospitalization requires a \$200 copay.
- There are no deductibles (except for prescriptions, which are covered under CIGNA for all medical options).
- No referrals are required for specialists' care, but pre-authorization is required for certain services (including, but not limited to, hospitalization, MRIs, CT scans, PT scans, and certain surgeries).
- Refer to page 9 for information about behavioral health (mental health and substance abuse) coverage and page 10 for information about prescription drug coverage.

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\*For subsidized agents only.

MassMutual offers the following In-Network-Only (HMO-like) Options (based on your residential ZIP code):

- Blue Cross Blue Shield Advantage Blue
- Aetna Select Open Access (formerly Aetna EPO)
- CIGNA OAP In-Network (formerly CIGNA EPO)

## **CIGNA**

*Three different medical options are offered through CIGNA: The CIGNA OAP In-Network option (described above), Med 500 and the High Deductible Health Plan (HDHP). Each of these options provides participants access to the 24-Hour Health Information Line.<sup>SM</sup> This service provides 24-hour toll-free access to registered nurses and an extensive audio health information library.*

## **Med 500**

CIGNA Med 500 provides coverage both in-and out-of-network, and using providers within the Open Access Plus (OAP) network may save you money.

*Key features:*

- You can visit any licensed medical provider in the country.
- You receive a higher benefit (saving you money) when you use providers in the CIGNA OAP network.
- You must pay a \$500 individual deductible (\$1,000 family maximum) before services – other than in-network office visits and preventive care – are covered; generally, you pay just a \$15 or \$30 copay for in-network office visits.
- After the deductible, you pay 10% of charges in-network; out-of-network, you pay the balance of charges after the plan pays 70% of reasonable and customary (R&C) charges\* for most services. In other words: Out-of-network, your portion is at least 30% of the charges, but may be more if the provider you use charges more than R&C for services.

- No referrals are required, but pre-authorization is required for certain services including hospitalization, MRIs, CT scans, PT scans, and certain surgeries.
- Refer to page 9 for information about behavioral health (mental health and substance abuse) coverage and page 10 for information about prescription drug coverage.

## **High Deductible Health Plan (HDHP)**

Administered by CIGNA, the HDHP has the highest deductible and lowest cost per commission voucher of all the medical options.

Under the HDHP, you must meet the \$1,500 individual annual plan deductible if you cover ONLY yourself in the plan, before benefits (other than in-network preventive care and certain preventive prescriptions) begin to be paid for you. You must meet the full \$3,000 family annual plan deductible if you cover yourself AND any one or more dependents under the plan, before benefits (other than in-network preventive care and certain preventive prescriptions) begin to be paid for ANY covered member. *Note:* There is **not** a separate prescription drug deductible for this option. The HDHP has a combined medical and prescription drug deductible.

*Key features:*

- After you meet the deductible, the plan pays 90% and you pay 10% of charges for services provided in-network. (Most in-network preventive care services are covered 100% with no deductible.)
- Out-of-network, after you meet the deductible you pay the balance of charges due once the plan pays 70% of R&C charges for most services. In other words: Out-of-network, your portion is at least 30% of the charges, but may be more if the provider you use charges more than R&C for services.

After you meet the HDHP deductible, you pay a percentage of your prescription drug costs, subject to certain minimums

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\*The R&C charge is the amount charged by most providers in your provider's geographic area for the same service or supply.

and maximums and the plan pays the rest. Note: For certain preventive maintenance prescriptions, the deductible is waived and you pay only the coinsurance. And, *most smoking cessation drugs are covered without the deductible OR coinsurance.* (see “Prescription Drug Coverage” on page 10, for more information.)

Because the HDHP is a federally qualifying plan, a participant may contribute to a Health Savings Account (HSA). This means you can pay for qualified out-of-pocket health expenses (including prescription drugs and eligible over-the-counter items) with tax-free\*\* dollars from this account. CIGNA offers an HSA through which you can contribute on a pre-tax,\*\* commission-voucher deducted basis. However, you can elect any HSA you choose, or none at all. See the HSA section on this page for more information.

### **How the HDHP Individual and Family Deductibles Work**

Because the HDHP deductible works differently than most other medical options, we want to be clear. *Beyond preventive care and certain preventive maintenance drugs*, HDHP participants must pay for both medical and prescription drug expenses out of pocket up to the deductible – either \$1,500 for those who cover themselves alone, or up to \$3,000 for those who cover themselves and one or more eligible dependents, before any benefit begins being paid. In other words: If you cover any dependents under your HDHP option (even just one person other than yourself), you must satisfy the entire \$3,000 deductible before the HDHP begins paying benefits for you or any one of your covered dependents. Once you meet the deductible, you pay 10% of charges for services provided in-network and 30% of R&C charges out-of-network.

*Note:* If you participate in the HDHP and you contribute to a health-care FSA, you may only pay for eligible dental and vision care expenses from your FSA. However, you can pay for eligible medical, prescription drug and over-the-counter

### **CIGNA offers the CIGNA ChoiceFund<sup>SM</sup> HSA through JPMorgan Chase**

For your convenience, MassMutual facilitates pre-tax,\*\* commission-voucher deductions for non-financed agents to an HSA through CIGNA, which partners with JPMorgan Chase. You can also make contributions to an HSA by check. For information on opening a JPMorgan Chase HSA, go to My Benefits and go to the CIGNA Choice Fund Health Savings Account (HSA) page.

**Tip:** Be sure to familiarize yourself with the JPMorgan Chase HSA features and rules. Remember: You do not have to open a JPMorgan Chase HSA or any HSA at all when you elect the HDHP. It's your choice. Consult a tax advisor to understand any tax implications.

expenses from a health savings account (HSA), if you contribute to one.

### **Health Savings Account (HSA)**

You are eligible to contribute to an HSA if you enroll in the HDHP. HSAs can help you save with pre-tax dollars\* for current or future qualified health care expenses for you and your eligible dependents. See “CIGNA offers the CIGNA ChoiceFund<sup>SM</sup> HSA through JPMorgan Chase” above.

*Key features:*

- HSAs offer a triple tax advantage\*
  - Tax-free contributions
  - Tax-free earnings on contributions
  - Tax-free withdrawals (for qualified expenses, including eligible medical expenses in retirement)

\* Alabama, California, New Jersey and Wisconsin include HSA contributions and earnings on those contributions as taxable income.

\*\* For subsidized agents only.

- Examples of qualified expenses include:
  - medical expenses, including office visit copayments or coinsurance and deductibles
  - prescription drug expenses purchased in the US
  - dental expenses
  - vision care expenses
  - COBRA health premiums
  - health premiums while unemployed
  - qualified long-term care insurance (the amount considered a qualified medical expense depends on your age; see IRS Publication 502 for the amounts deductible by age)
  - health premiums once age 65 if retired (not including supplemental health insurance such as “Medigap”)
- Contributions to an HSA earn interest and can be invested in certain funds once your account balance is greater than \$2,000.
- Your HSA stays with you even if you change medical options, leave the Company or retire.
- There is NO “Use or Lose” feature. You do not forfeit money remaining in your HSA at the end of each calendar year.
- In 2009, you can contribute up to \$3,000 (individual) or \$5,950 (family) to an HSA. If you are age 55 or older, you can contribute an additional \$1,000 in “catch-up” contributions. For more information, go to My Benefits and click on the “ ‘Catch up’ contributions” link on the CIGNA Choice Fund Health Savings Account (HSA) page.
- For your convenience, your contributions can be commission-voucher deducted on a pre-tax\* basis. If you join the CIGNA Choice Fund HSA before Jan. 1, 2009, you can contribute the full amount (\$3,000 individual or \$5,950 family) via pre-tax\* commission-voucher deduction. If you join the CIGNA Choice

Fund HSA between Jan. 1-Dec. 31, you can contribute a pro-rated amount via pre-tax commission-voucher deduction (For example, if you joined in June, you could contribute a maximum of \$1,500 (individual) via commission-voucher deduction July through December (\$250 per month for six months). However, you could always send a check to JPMorgan Chase for up to the remaining amount, \$1,500 in this example – it just won’t be through commission-voucher deduction. Be sure to consult your tax advisor for tax implications.

- If you do not set up a commission-voucher deducted account with CIGNA Choice Fund HSA within 31 days of initial enrollment or during subsequent annual benefits enrollment periods, you will not be able to set one up until the following annual benefits enrollment period. You can always set up an HSA that is not commission-voucher deducted.
- Once your account is set up, you can change your HSA contributions on a month-by-month basis.

### The Health-care FSA and the HDHP

If you are enrolled in the HDHP and the Health-care FSA, you can only use your Health-care FSA for eligible dental and vision expenses; you cannot use your Health-care FSA for medical expenses – that’s where the Health Savings Account (HSA) comes in. For example, you cannot submit to your Health-care FSA for reimbursement of your medical deductible or copayments, prescription drug expenses or eligible over-the-counter items. However, you can use an HSA to pay for your qualified health expenses, including your HDHP deductible and copayments, prescription drug expenses and eligible over-the-counter items.

\* For subsidized agents only.

## CIGNA Medical Tools You Can Use

If you are considering a CIGNA medical option, you may want to go to [myCIGNAplans.com](http://myCIGNAplans.com). *What you'll find:*

- Tools to help you estimate your costs for the coming year. For example: You can compare your CIGNA options, side by side, including your per-commission-voucher contributions
- An HSA calculator to determine your maximum contribution and estimate your tax savings
- A directory of doctors, hospitals and other facilities that participate in the CIGNA Open Access Plus network
- Benefit summaries that highlight what your plan covers
- Average costs of common procedures and diagnoses
- Frequently asked questions and answers
- A glossary of medical and dental terms

*How to log on:* Use the following ID: mmagents; password: cigna. (IDs and passwords are case-sensitive.)

## Disease Management and Your Medical Option

All MassMutual medical options offer disease management programs. Why should you participate? They can help you:

- Take charge of your own health and manage chronic conditions
- Get the most appropriate treatment and preventive care for your individual needs
- Understand how to follow your doctor's treatment plan
- Make the changes necessary to reach your personal health goals
- Identify and manage your risks for other conditions

In other words, you'll have access to someone who will take a comprehensive view of your health and help you navigate care options. If you or a covered dependent has a chronic condition or disease, you may receive a phone call or a letter from a Registered Nurse (RN) affiliated with your medical carrier's disease management program. This nurse can help

you navigate the healthcare system for the information and treatment options that are right for you and provide you with personalized educational material, including tips for talking to your doctor about your health.

Since disease management is built into your medical option, there's no extra cost to you for these services. And participation is completely voluntary – it's up to you. Some examples of chronic conditions and diseases that the program can help with include:

- Asthma
- Low back pain
- Cancer
- Migraine
- Coronary artery disease
- Obesity
- Diabetes
- Osteoporosis
- IBD/Crohn's
- Smoking cessation

Listed below are the names of the disease management programs offered by your medical options:

- Aetna's program is Informed Care Management, administered by Active Health Management®.
- CIGNA's programs are called Well Aware for Better Health and Personal Health Solutions Plus (PHS+)
- BCBS Advantage Blue's program is Informed Care Management, administered by Active Health Management®.

## Mastectomy-related Services

MassMutual's medical options, as required by the Women's Health and Cancer Rights Act of 1998, provide benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For details, contact your medical carrier.

# Mental Health and Substance Abuse (Behavioral Health) Services

Mental Health (MH) and Substance Abuse (SA) services are managed by Aetna Behavioral Health for participants in all medical options *except* the HDHP. Aetna Behavioral Health also administers the Agent Assistance Program (AAP) for **all** career agents. (See page 22 for more information on MassMutual's AAP.)

**Here's how it works:** We encourage you to go through the Aetna AAP whenever you feel you need behavioral health services (including those for mental health and substance abuse). Going through the AAP offers you additional benefits, including free counseling sessions (up to six per incident, with no limit on the number of incidents per year) and free informational materials.

*Key features:*

## Office visits\*

- **In-network:** You pay a \$15 copay for MH and SA office visits. There is no limit on the number of in-network office visits per year.
- **Out-of-network:** You pay 30% of R&C for MH and SA office visits with a 20-visit annual maximum (after your 20th out-of-network visit, you pay 100% for subsequent visits).

## Hospital services

- You pay a \$200 copay per admission, whether in- or out-of-network.
- **In-network:** After copay, you pay 10% for hospital services with no limit on the number of days.
- **Out-of-network:** After copay, you pay 30% of R&C changes for hospital services with a 20-day annual maximum.

- **Pre-certification:** Pre-certification for in-network MH and SA services is generally not required. However, *inpatient hospitalization* must be pre-certified.
- If you use in-network MH and SA providers, hospitalization is automatically pre-certified.
- If you use providers outside the Aetna Behavioral Health network, you must contact Aetna Behavioral Health to obtain pre-certification. There is a **\$500 penalty for not receiving pre-certification** for inpatient hospitalization at a hospital outside the network.
- **Certain outpatient services also require pre-certification** when provided out-of-network. You must call Aetna before receiving any of the following services, to avoid the \$500 penalty:
  - Psychological testing
  - Neuropsychological testing
  - Outpatient Electroconvulsive Therapy (ECT)
  - Biofeedback
  - Amytal interview
  - Hypnosis
  - Psychiatric home care services
  - Outpatient detoxification

## Residential Substance Abuse Programs

There is a *lifetime maximum* of three inpatient residential substance abuse programs per person.

## The Bottom Line?

Call Aetna Behavioral Health for all MH and SA services at the number listed on the back of your medical ID card – or refer to your separate Aetna Behavioral Health ID card.

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\*If you initiate care through the AAP, your first six counseling visits per incident are free (there is no limit on the number of incidents per year). These visits are free only if coordinated by the AAP and only for non-acute, non-emergency, office visits. CIGNA members in the HDHP are also eligible for services through the AAP, including the six free counseling visits, even though they have their MH and SA services administered by CIGNA.

# Prescription Drug Coverage

CIGNA administers the prescription drug feature for all MassMutual medical options. So whether you enroll in medical coverage with Aetna, CIGNA or BCBS Advantage Blue, your prescription drugs are covered through CIGNA.

## Tip

Tier 1 (generic) drugs are generally the least expensive, and they are therapeutically equivalent to their brand-name counterparts. They are sold under the chemical or scientific name for the drug instead of the manufacturer's brand name.

### *Key features:*

- You pay your annual deductible (\$50 individual/\$100 family maximum for all options except the HDHP, which has a combined medical and prescription drug deductible – see High Deductible Health Plan on page 5 for deductible amounts).
- You pay a percentage of the cost of each 30-day supply\* prescription, either 15%, 30% or 50% up to a certain maximum. There is also a minimum charge for drugs.
- The percentage you pay and the minimums and maximums are based on whether your drug is categorized as generic, preferred brand or non-preferred brand:
  - Generic: You pay 15% up to \$20 per prescription. Minimum charge is \$5 (or total drug cost, if less)
  - Preferred brand: You pay 30% up to \$80 per prescription. Minimum charge is \$25 (or total drug cost, if less)
  - Non-preferred brand: You pay 50% up to \$100 per prescription. Minimum charge is \$25 (or total drug cost, if less)
- If you reach the annual prescription drug out-of-pocket maximum (\$1,500 per individual for all options except the HDHP), prescriptions are covered 100%.

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\*CIGNA covers 90-day prescriptions through Tel-Drug at the same percentages. Minimums and maximums are approximately two-and-one-half times those of a 30-day supply. See the prescription section of the Medical Comparison Chart for details. Note: Getting prescriptions from Tel-Drug may not be the least expensive route. See "Prescription Shopper Tool" on page 11.

- CIGNA covers 30-day supplies of prescriptions at retail pharmacies or 90-day supplies of maintenance prescriptions through Tel-Drug, CIGNA’s mail-order service. In other words: You can refill your prescriptions as many times as prescribed, but you can’t buy more than one or three months of prescriptions at a time, depending on how you purchase them.
- CIGNA’s prescription drug formulary list (which determines the tier under which a drug is categorized – generic, preferred or non-preferred) can change based upon the introduction of new drugs. Before filling a prescription, it may save you money if you first go to CIGNA’s online health care prescription drug list on [www.mycigna.com](http://www.mycigna.com) to ensure the drug is covered and under which tier it falls. You may want to talk with your doctor to see if lower-cost alternatives are available and appropriate for you and your condition.
- See the 2009 Medical Comparison Chart for more details.

**Note:** For certain medications, your doctor must contact CIGNA to request pre-authorization. To see a list of prescription drugs that require pre-authorization, please go online to My Benefits. Choose your health option and click the “More about prescription drugs” link. Pre-authorization may be required for drugs not on this list. For example, if prescribed certain dosages for a medicine that exceed those typically prescribed, or if prescribed a medication not typically used for your condition. In sum: When in doubt, contact CIGNA.

### Prescription Shopper’s Tool

Once you are a participant in a medical option and become part of CIGNA’s prescription drug plan, you may want to register on [www.mycigna.com](http://www.mycigna.com). This site provides a prescription pricing tool that allows you to see how much you’ll pay for a certain drug. *How it works:*

- Go to [www.mycigna.com](http://www.mycigna.com)
- Register (or log in, if you have already done so)
- Click the “My Plans” tab, and then the “Pharmacy” tab
- Under “Prescription Drug Price Quotes,” click “Find prescription drug price quotes”
- Follow the system prompts to look up your medication, including the dosage amount
- Click on “Select a Pharmacy” and complete the fields to find and select a pharmacy near you
- Once your pharmacy choices are in place, click “Compare Prices”

The result? You’ll see three dollar amounts: Member Cost, which is the approximate cost you would pay at the pharmacy; Health Plan Cost, which is the balance that the plan would pay; and Total Cost, the full cost of the medication you’re planning to purchase.

But you won’t want to stop there: You can repeat the process as often as you want, for example to see if purchasing a 90-day supply via mail order will save you money.

### Checking Provider Networks

Visit the carrier’s website or call the carrier directly to find out if a certain provider is in the medical option network. Instructions for accessing online provider directories are on the flip-side of the Benefit Contacts list.

# ID Cards

## Medical ID Card

Once your benefits enrollment is processed, you'll be sent medical ID cards. Depending on your medical option, each family member will get an individual card or you will be sent two cards with all members listed on each card. If you lose your card or need additional copies, simply contact your medical carrier.

## Prescription Drug ID Card

You will receive a separate prescription drug ID card from CIGNA. However, if you are a participant in a CIGNA medical option, you will receive a combined medical and prescription drug ID card. If you lose your card or need additional copies, contact CIGNA.

## Behavioral Health ID Card

You will receive a separate Aetna Behavioral Health ID card for all mental health and substance abuse services. Or you can call the mental health and substance abuse phone number listed on the back of your medical ID card. If you lose your card or need additional copies, contact Aetna Behavioral Health.

## Health Savings Account (HSA) Card

HDHP participants who have completed their initial online bank application with JPMorgan Chase will be sent their HSA debit cards. If you lose your card or need additional copies, contact JPMorgan Chase.

## Health Care FSA "Debit" Card

Health Care FSA participants will be sent an FSA debit card from WageWorks. If you lose your card or need additional copies, contact WageWorks.

# Dental

MassMutual offers coverage for you and your eligible dependents. There are two dental plan options, both administered by CIGNA.

## Dental options

	CIGNA Basic Dental	CIGNA Major Dental
Cost per commission voucher	<b>Subsidized Rates</b> <b>Individual (Ind.):</b> \$4.41 <b>Ind. + Spouse/DP:</b> \$9.63 <b>Ind. + Child(ren):</b> \$8.82 <b>Family:</b> \$13.76	<b>Subsidized Rates</b> <b>Individual (Ind.):</b> \$10.38 <b>Ind. + Spouse/DP:</b> \$22.75 <b>Ind. + Child(ren):</b> \$20.75 <b>Family:</b> \$32.25
Cost per commission voucher	<b>Unsubsidized Rates</b> <b>Ind.:</b> \$14.16 <b>Ind. + Spouse/DP:</b> \$31.15 <b>Ind. + Child(ren):</b> \$28.32 <b>Family:</b> \$43.89	<b>Unsubsidized Rates</b> <b>Ind.:</b> \$25.00 <b>Ind. + Spouse/DP:</b> \$55.00 <b>Ind. + Child(ren):</b> \$50.00 <b>Family:</b> \$77.50

### Deductible

Per individual	\$50	\$50
Per family	\$200	\$200

### Services

### Plan Pays\*

Preventive and Diagnostic Care (Type I)	100% of R&C no deductible	100% of R&C no deductible
Basic Restorative Care (Type II)	80% of R&C after deductible	80% of R&C after deductible
Major Restorative Care (Type III)	Not covered	50% of R&C after deductible
Orthodontia (Type IV)	Not covered	50% no deductible (\$2,000 lifetime maximum)

### Maximums

Calendar year per person dental services	\$1,500	\$2,000
Lifetime orthodontia, per person	Not covered	\$2,000

### Examples of Covered Services: Types I, II, III and IV

Preventive and Diagnostic Care (Type I)	Cleanings, fluoride treatment (up to age 15), routine exams, sealants (up to age 18), space maintainers, x-rays
Basic Restorative Care (Type II)	Anesthesia, extractions, fillings, oral surgery, root canal
Major Restorative Care (Type III)	Bridges, crowns, dentures, gold restorations, inlays, periodontics, TMJ (temporomandibular joint), implants
Orthodontia (Type IV)	Orthodontia, retainers

\* If you see a dental provider who is in the CIGNA dental PPO network, the charges will always be at or below reasonable and customary (R&C) guidelines.

## Deductibles, Coinsurance and the “Reasonable and Customary” (R&C) Guideline

All services, except for preventive care and orthodontia, are subject to a deductible, which is the amount you pay each year before the plan begins paying benefits.

After you meet the deductible, covered expenses are paid as a percentage of the R&C allowance for each service. The R&C allowance is the amount charged by most dentists in your dentist’s geographic area for the same service or supply.

**How R&C works:** Consider, for example, you need to go to the dentist for a filling. This qualifies as basic restorative care (Type II), paid at 80% of R&C (after you meet the deductible).

Assuming you have already met the deductible:

- **If you go to Dentist A** and the charges for a filling fall within R&C guidelines, you will pay the 20% balance due.
- **If you go to Dentist B** and the charges for this service are above the R&C guidelines, the plan pays 80% of *R&C charges*. It does not pay anything for charges above R&C. Result: You pay the balance due Dentist B, which in this instance would be more than the 20% you would owe if you used Dentist A.

### Note

You will not receive a dental ID card. Instead, provide your dentist with a copy of the CIGNA dental claim form that you can find through the “Forms” link on My Benefits.

So, while you may use the services of any licensed dentist you choose, if you choose a dentist within the CIGNA Dental PPO network, your out-of-pocket expenses may be lower. Network provider fees are always within the reasonable and customary (R&C) guideline charges, whereas out-of-network providers may or may not charge more.

To find a dentist in the PPO network: Go to CIGNA’s website ([www.cigna.com](http://www.cigna.com)), click on “Provider Directory” in the left-hand column on the home page, select dentist and then complete other fields as required, then select a specialty in the pull-down menu under the dental plan CIGNA Dental PPO. Click “Continue,” and a list of in-network dentists should appear.

### What “Types” of Dental Coverage Do You Need?

Not sure if you need the Basic or Major dental option for yourself or your eligible dependents? Click on the “Covered services list” link provided on each dental plan’s home page on My Benefits for information on what is and isn’t covered – from anesthesia to x-rays and just about everything in-between.

# Vision

The vision option (administered by CIGNA) is a reimbursement plan that is not subsidized by MassMutual – agents pay the full cost.

*How it works:* You receive services from any licensed ophthalmologist or optometrist you choose. You pay for the services you and your covered dependents receive, then file a claim to be reimbursed for eligible expenses, up to certain limits, as shown in the chart below. Vision claim forms are available on My Benefits under ‘Forms.’

**Key feature:** You may not receive a benefit for both contact lenses and eyeglass lenses within the same 12-month period.

## Cost per commission voucher

- **Individual:** \$2.41
- **Individual + Spouse/DP:** \$5.30
- **Individual + Child(ren):** \$4.82
- **Family:** \$7.47

### Note:

If you are enrolled in one of the In-Network Only medical options, vision exams may be covered under your medical option. Refer to the medical comparison chart or contact your medical carrier for details.

## Vision care benefits

	The plan pays up to	How often
Vision exams (by a licensed ophthalmologist or optometrist)	\$65	Every 12 months
Eyeglass frames	\$75	Every 24 months
Single vision lenses	\$75	Every 12 months
Bifocal lenses*	\$85	
Trifocal lenses*	\$95	
Lenticular lenses	\$115	
Necessary/Elective contacts**	\$125	

\* This benefit also applies to progressive lenses.

\*\* Only one claim for contact lenses (in lieu of eyeglass lenses) are eligible for payment each year. In order to make use of your full \$125 contact lens allowance, please purchase a supply of contact lenses that will exhaust the entire allowance at one time.

# Flexible Spending Accounts (FSAs)\*

MassMutual offers two flexible spending accounts (FSAs), also known as reimbursement accounts:

- A Health-care FSA for qualified health care expenses for you and your eligible dependents
- A Dependent (child/elder) Care FSA for qualified dependent care expenses

These accounts (administered by WageWorks) allow you to take advantage of tax savings – from 15%-39%, depending on your tax bracket – when paying for either eligible health-care or dependent-care (child- or elder-care) expenses. For an example of how you can save, see “How an FSA Can Help You Save” on page 18. *Note:* If you participate in both FSAs, you cannot transfer funds between accounts.

Plan carefully when choosing the amount to contribute to your FSA because according to the IRS “Use or Lose” rule, you will lose any money not used for eligible expenses during the year.

You can submit expenses up until March 31, 2010 for charges incurred January 1 – December 31, 2009 (generally while you were a plan participant).

## Health-care Flexible Spending Accounts (FSAs)

The Health-care FSA allows you to put pre-tax money aside in an account to pay for qualified health-care expenses not covered by another health plan.

### Key features:

- You contribute through commission-voucher deduction on a pre-tax basis up to \$5,000 per year (minimum \$120 per year)
- When you have eligible health-care expenses not covered by another plan, you can be reimbursed from your Health-care FSA by:
  - completing a “Pay Me Back” form with attached receipts and faxing or mailing it to WageWorks (the company that administers the FSAs), or
  - paying with your WageWorks FSA pre-loaded debit card at the time of service or purchase.

**Note:** If you participate in the HDHP, you can use a health-care FSA for eligible dental and vision care expenses ONLY.

It’s important to keep your receipts because you may need to submit them to WageWorks as proof of qualified expenses. If you use your WageWorks card and you do not provide receipts within 60 days of the request, your card will be shut off. Also, effective January 1, 2009, WageWorks and other debit cards linked to health-care FSAs can only be used at merchants with a Health Care Category Code (MCC) – generally health care provider offices and pharmacies. However, the card can be used at most major national chains (including Walgreens, CVS, WalMart, Sam’s Club, etc.), which have adopted the new, IRS-approved Inventory Information Approval System (IIAS).

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\*Unsubbed agents are not eligible for FSAs.

## The Health-care FSA and the HDHP

If you are enrolled in the HDHP and the Health-care FSA, you can only use your Health-care FSA for eligible dental and vision expenses; you cannot use your Health-care FSA for medical, prescription drug or over-the-counter expenses – that’s where the Health Savings Account (HSA) comes in. You **can** use an HSA to pay for your qualified health expenses, including your HDHP deductible, prescription drugs and eligible over-the-counter items.

## Eligible Over-the-Counter Remedies

A partial list of what’s covered: Acne preparations, allergy medicines, antihistamines, analgesics, antacids, anti-diarrhea medication, aspirin, cold medicine, contact lens solution, cough drops, first aid cream (Bactine, special diaper rash ointments, calamine lotion, bug bite medication, wart remover treatments), hemorrhoid medications, homeopathic medicines, laxatives, lice and scabies treatment, menstrual cycle products (for pain and cramp relief), motion sickness pills, muscle/joint pain relief (Ben-Gay, Tiger Balm), nasal sinus spray, nasal sprays (for snoring), nicotine gum/patches, ophthalmic preparations (eye drops), pain reliever, Pedialyte, pills for persons who are lactose intolerant, pregnancy tests, pre-natal vitamins, reading glasses, retin A (non-cosmetic), rubbing alcohol, sinus medications, sleeping aids, smoking cessation products, special foods (cost difference of common product with medical certification), special ointment/cream for sunburn, throat lozenges, vapor rub, and wound care products. (For more information on eligible expenses, go to the Health-care FSA section of My Benefits or to [www.WageWorks.com](http://www.WageWorks.com)).

## The “Use or Lose” Rule and the Health-care FSA

Far too many agents don’t take advantage of Health-care FSAs because they are afraid of the “Use or Lose” rule. They are convinced they will over-estimate their expenses for the year and end up watching their balance disappear at year-end – along with all of their expected savings.

This doesn’t have to happen. Many people successfully use Health-care FSAs and save money, year after year. There are at least three strategies for doing this:

1. Calculate your estimated expenses carefully. There are tools available on the WageWorks website ([www.wageworks.com](http://www.wageworks.com)) to estimate your expenses.
2. Check your balance throughout the year and proceed accordingly. If you still have a substantial balance in the fall, for example, you may want to schedule overdue medical or dental exams. Perhaps you will be able to apply your remaining balance to dental work or new eyeglasses or contact lenses.
3. If the end of the year is near and you still have money in your account, you can stock up on eligible over-the-counter medicines and medical devices. You might be surprised by how many items you use every day that can be purchased with dollars from your Health-care FSA.

## The Dependent Care FSA

The Dependent Care FSA (for child-care or elder-care services) allows you to put aside money before taxes are withheld so that you can pay someone to care for your eligible dependents (e.g. children under age 13) while you and your spouse (if you are married) work.

### Key features:

- If you are married and your spouse is not employed, dependent-care expenses are not eligible for reimbursement, unless your spouse is actively seeking employment, a full-time student or physically or mentally incapable of self-care.
- In general, the plan reimburses dependent-care expenses for day care provided to your qualified dependent(s) in the plan year you make contributions, and would otherwise be eligible for the dependent-care tax credit on your tax return.
- You can contribute up to \$5,000 (if single filing as head of household or married filing jointly) or \$2,500 (if married and filing individually), but no more than the lesser of either your or your spouse's earned income.
- If eligible, the minimum you can contribute is \$120 per calendar year.
- When you have eligible reimbursable expenses, you can receive your money back tax-free, up to the amount that is in your account when you ask for reimbursement.

*A caveat:* Participating in the Dependent (child/elder) Care FSA will reduce or eliminate your ability to use the federal child and dependent-care tax credit. For many taxpayers, using a Dependent Care FSA will result in a greater tax savings than the federal child and dependent-care tax credit. However, each situation is unique. If you are uncertain about the comparative advantages of the Dependent Care FSA versus the federal child and dependent-care tax credit, you may wish to consult with a tax advisor. To learn how to calculate your tax savings, go to [www.irs.gov/taxtopics](http://www.irs.gov/taxtopics) and enter Topic 602, or call the Internal Revenue Service toll-free at 800-829-1040 for assistance.

## How an FSA Can Help You Save

Why put money into an FSA? If the peace of mind of having money set aside for health-care or dependent care expenses isn't enough, consider this: An FSA can reduce your taxes, thereby boosting your take-home pay.

	Agent A (with FSA)	Agent B (without FSA)
Gross income	\$55,000.00	\$55,000.00
Pre-tax contribution to a Health-or Dependent-care FSA	\$800.00	\$0
Taxable income	\$54,200.00	\$55,000.00
After-tax income *	\$39,213.70	\$38,992.50

\* Assumes 15% federal income tax, 5% state income tax and 7.65% Social Security tax.

*For example:* Take Agent A, who earns \$55,000 a year and decides to contribute \$800 to an FSA. Compare her experience with Agent B, who earns \$55,000 and contributes nothing. The result? By electing the FSA, Agent A reduces her taxable income by \$800 and sees approximately \$221.20 more in take-home pay. In addition, she can access the \$800 she put in the FSA to pay for qualified expenses. If Agent B had eligible expenses, he would have to pay these expenses with his take-home, post-tax income.

# Life Insurance

## Group Term Life Insurance

MassMutual provides group term life (GTL) insurance protection if a subsidized, career contract agent dies while under contract with MassMutual. No contribution is required for basic life insurance equal to a career contract agent's annual benefits pay, up to \$50,000.

Supplemental life insurance of one, two, three, or four times annual benefits pay is also available at group rates as follows:

- 1 time your annual benefits pay, rounded to the next highest \$100, up to \$150,000
- 2 times your annual benefits pay, rounded to the next highest \$100, up to \$250,000
- 3 times your annual benefits pay, rounded to the next highest \$100, up to \$350,000
- 4 times your annual benefits pay, rounded to the next highest \$100, up to \$450,000

*Combined coverage limit:* Basic Life Insurance and Supplemental Life Insurance combined cannot exceed \$500,000.

## Guaranteed Issue if You Enroll within 31 Days of Becoming Eligible

If you enroll within 31 days of the date you first become eligible, you are guaranteed issue of life insurance. (And if you don't enroll, you are automatically enrolled in Company-paid insurance for one times your base pay.) In other words, no proof of good health is required. However, if you increase your coverage more than one step – for example, opting for 3 times your annual benefits pay up from 1 – during a subsequent Benefits Enrollment or when you have a qualifying change in status, proof of good health is required.

## Accidental Death and Dismemberment Coverage

In addition, the Company pays for accidental death and dismemberment (AD&D) coverage in the same amount as your group term life insurance at no cost to eligible subsidized career agents.

## Supplemental Group Term Life (GTL) Insurance Age Brackets and Associated Rates

Your cost for supplemental GTL insurance is based on your coverage amount and age on December 31 of the prior plan year. Your supplemental GTL insurance costs may increase during the year if your annual benefits pay increases or on the first of the following year if you enter a different supplemental GTL insurance age bracket during the year (since costs are determined annually).

Age Bracket for Supplemental Life Insurance (your age as of 12/31/08)	2009 Cost (per \$1000 of supplemental GTL coverage)
< 30	\$0.06
30-34	\$0.07
35-39	\$0.08
40-44	\$0.09
45-49	\$0.14
50-54	\$0.21
55-59	\$0.43
60-64	\$0.66
65-69	\$1.27
70 +	\$2.06

## Dependent Life Insurance

You can purchase dependent life insurance to cover your spouse or domestic partner and eligible children.

### Key features:

- Provides \$10,000 or \$20,000 of coverage on your spouse and \$5,000 or \$10,000 on each child.
- The cost is based on your age (not your spouse's or child's) and is deducted from your paycheck on a post-tax basis.
- If you and your spouse or domestic partner both hold career contracts with MassMutual, you may both elect this coverage.
- You are always the beneficiary for your dependent life insurance.

**Note:** The amount of dependent life insurance you choose cannot exceed 50% of your annual benefits pay, and you must have group term life insurance or group variable universal life insurance in the amount of at least one time your annual earnings (or \$50,000 if less).

## Strategic Edge Group Variable Universal Life Insurance for Top-Producing Agents

As an added incentive to certain high-producing agents, MassMutual offers \$150,000 in company-paid group variable universal life insurance (GVUL) if you are age 65 or younger and meet the qualification requirements under the Massachusetts Mutual Group Universal Life Plan for Top Producers. If you meet qualification requirements for Strategic Edge Group Variable Universal Life (GVUL) Insurance, you will receive an informational packet from Executive Group Life prior to March 1 of each year.

**Note:** The amount of GTL you elect when first eligible or during subsequent enrollments determines the amount of GVUL you may elect without evidence of insurability. For more information, see the Agent Life SPD or call Executive Group Life at 800-548-0073, Ext. 24570, business days 8 a.m. – 5 p.m. ET.

# Disability

## Short Term Disability (STD)

After 30 consecutive calendar days of absence due to injury or sickness, or after seven consecutive calendar days for pregnancy, you may be eligible for STD benefits. If you are unable to perform material and substantial duties of an active career contract agent because of an injury or sickness, you may be eligible to receive up to 22 weeks (up to 25 weeks for maternity) of STD benefits while disabled. MassMutual pays the cost for this coverage for subsidized agents.

## Long-Term Disability (LTD)\*

LTD offers protection if you remain disabled by serious injury or sickness for more than 180 consecutive calendar days. There are two benefit options with differing levels of coverage:

- **LTD 50** provides a benefit of up to 50 percent of prior year AAA Weighted Commission Credits (WCC) production (up to \$10,000 monthly) at no cost for subsidized agents.
- **LTD 70** provides a benefit of up to 70 percent of prior year AAA WCC production (up to \$20,000 monthly). You pay the cost of the additional coverage of LTD 70 above LTD 50 and can elect this contribution to be deducted on a pre- or post-tax basis.

*What's the difference?* If you pay for the buy-up coverage with post-tax dollars, the 20% will not be treated as taxable income to you if you become disabled and receive this benefit. If you pay for LTD 70 coverage with pre-tax dollars, the buy-up benefit is taxable upon receipt.

### Notes:

- As a newly-endorsed career contract agent, disability benefits are based on the current year AAA WCC production requirements. Unsubsidized agents pay the full cost for LTD coverage with post-tax dollars only.
- STD and LTD payments are offset by Social Security disability benefits received.
- Newly endorsed career contract agents who have received treatment for any illness or injury during the 12-month period prior to signing their contract with MassMutual: You will not receive LTD benefits if you become disabled as a result of that condition within the first 12 months of coverage under the LTD plan.

## Before and After, Benefits Style

As you read this booklet and other resources that MassMutual and our carriers provide to explain your benefit options, you may find they all don't use the same words to describe the same thing. For one very common example, consider the language used to describe the timing of automatic deductions and taxes. Some communications say "pre-tax," others say "before-tax." The good news? They both mean the same thing, as does the pairing of "post-tax" and "after-tax." However: If you're not sure what a carrier or even MassMutual is getting at, please ask.

## Changing Your Benefits During the Year

You can only change benefits once a year during annual benefits enrollment, for benefits effective the following January 1 – unless you have what the IRS defines as a “qualifying change in status,” including:

- Marriage, divorce or legal separation
- Birth or adoption (or placement for adoption, new foster child or legal guardianship)
- Ineligibility of dependent child
- Gain or loss of spouse’s employment or benefits
- Move out of network area (of your in-network medical option)
- Death

### If You Have a Qualifying Change in Status

If you have a qualifying change in status, call or e-mail MassMutual Benefits at 1-866-662-6448 or BenefitQuestions@MassMutual.com within 31 days of the change. *Key:* In most instances, documentation is required.

*Caveat:* All benefits changes must be “consistent with and on account of” your change in status. For example, if you get married, you can add your spouse and eligible dependents to your plan or drop coverage for yourself and any children if enrolling in your spouse’s plan. You can increase your life insurance, your LTD coverage and add FSA’s. Contact MassMutual Benefits for more information (see Benefit Contacts list).

## Other Benefits

### Agent Assistance Program AAP

In addition to managing behavioral health (mental health and substance abuse) claims for most medical options, Aetna also administers MassMutual’s AAP. Free, confidential support is just a call or a click away, anytime, day or night for all agents and all members of agents’ households – regardless of whether or not you have medical benefits with MassMutual.

Many people think that an AAP is only for people who need counseling. But the Aetna AAP is designed for anyone who could use a little help in managing demanding situations you encounter day-to-day. For example, the Aetna AAP has a wide variety of supportive services in areas such as:

- Personal and professional relationships
- Family life
- Daily stress
- Elder care
- Childcare
- Finances
- And more!

Visit the Agent Assistance Program (AAP) online at [www.AetnaEAP.com](http://www.AetnaEAP.com) (Company ID: mmagents) or call 800-683-6512 any time.

### Adoption Assistance

To help with the cost of adoption, MassMutual reimburses 100% of certain eligible expenses up to a maximum of \$5,000 per adoption for eligible career agents. This assistance is taxable income. Career agents who have had a career contract in place for at least one year from their contract endorsement date are eligible. Agents must have an active career contract in place on both the date application for benefits is made and on the date the reimbursement is made.

## Live Healthy, Live Well Program

MassMutual's popular wellness program, Live Healthy, Live Well, offers agents and their spouses or domestic partners the opportunity to learn about their health and ways they can make incremental changes to improve it. And if you participate in certain Live Healthy, Live Well programs and activities, there will be financial incentives (taxable) for those of you – and your spouse or domestic partner – who are participants in MassMutual medical options, too.

### *The incentives planned for 2009:*

- \$50 incentive for taking the Wellness Assessment by the designated date\*
- \$100 incentive for successfully completing the 2009 program (i.e. earned all the points in the program by the designated date\*)

To be eligible, you must be a MassMutual medical option participant when the incentive is earned and paid out. The good news? If you're an agent who is not a participant in a Company medical option, you still qualify for the advice, on-line programs, information, and guidance available on the site 24/7 – you just don't qualify for the financial (and taxable) incentives.

Visit [www.massmutual.com/livewell](http://www.massmutual.com/livewell) for:

- A wellness assessment (this personalized, confidential tool can help you determine your top health priorities and the steps you can take toward improvement)
- Healthy recipes and nutritional information
- An animated weight-training exercise guide (your own virtual trainer)
- Sports training tips and sample workouts (for baseball, softball, basketball, biking, football, golf, running, rugby, soccer, swimming, tennis, racquetball, volleyball)

- An in-depth health library, medical encyclopedia and pregnancy center
- Chronic-care guides (for allergy, asthma, cholesterol, exercise, high blood pressure, low back pain, diabetes and weight loss)
- HabiTracker (use this tool to track your eating and exercising habits)
- And much more!

**Note:** Newly contracted agents will be sent an e-mail from Benefit Communications alerting them when they are able to log into the site (usually about a month after their contract dates). The first time an agent or the agent's spouse or domestic partner logs onto [www.massmutual.com/livewell](http://www.massmutual.com/livewell), he or she uses the agent's AA number (e.g. AAO12345, then chooses his or her own unique username and password.)

## For Information on All Your Benefits

### **My Benefits**

*My Benefits* is your online resource for detailed and personalized benefits information. You don't have to dig through files or piles of paper on your desk to find your enrollment booklet, simply turn to My Benefits whenever you need to, wherever you are.

By following the *My Benefits* link on FieldNet > My Practice > Benefits or going to <https://mmfgonline.massmutual.com> from home, you'll find Summary Plan Descriptions (SPDs), benefits comparison charts, contact information, an overview of your benefits coverage, and much more. While My Benefits provides a lot of information, unlike a paper document, it doesn't require you to leaf through it all to find what you need. There's a handy "Search" window on the site that can suggest a number of sources for the information you seek. Or, browse the categories in the navigation menu.

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\*Refer to [www.massmutual.com/livewell](http://www.massmutual.com/livewell) in 2009 for complete program details.

# Notice of HIPAA Privacy Practices

## MassMutual Health Plans

*This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.*

### **This notice becomes effective April 14, 2007.**

This Notice has been updated effective April 14, 2007 to add the Retiree Assistance Program (RAP) and update vendor privacy contact information.

### **Your privacy is important to us**

As the benefits management subsidiary for Massachusetts Mutual Life Insurance Company (MassMutual, Plan Sponsor) and subsidiaries, MassMutual Benefits Management, Inc. (MMBMI), on behalf of the MassMutual group health and medical flexible spending account (FSA) plans and programs listed below<sup>1</sup> is committed to protecting the privacy of your protected health information.

“Protected health information” (PHI) is your individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer, or a health care clearinghouse that relates to: (1) your past, present or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present or future payment for the provision of health care to you. Your employment information, sick leave records, Family and Medical Leave

information, Workers’ Compensation files, short-term and long-term disability, life insurance and OSHA records are not PHI and are not covered by this Notice.

This Notice describes the Plans’ privacy policies, safeguards and practices, and your rights concerning your PHI. Throughout this Notice, the Plans are referred to as “we,” “us” or “our.” We are required by federal and state laws to maintain the privacy of your PHI. A federal law known as HIPAA<sup>2</sup> regulates the Plans’ use and disclosure of PHI. You may find these regulations at *45 Code of Federal Regulations Parts 160 and 164* or you can obtain a copy of them from MMBMI upon request. The regulations will supersede any discrepancy between the information in this Notice and the regulations. We are required to abide by the terms of this Notice.

We will review our privacy practices on an ongoing basis to ensure the privacy of our Plan participants’ PHI. We reserve the right to change the terms of this Notice and to make new Notice provisions effective for all PHI the Plans maintain. If there is a material change to any provision of this Notice, we will distribute revisions by mail or electronic means to all affected Plan participants in advance of the change.

In the event some states provide additional or greater rights than described here, we will provide any required amendment to this Notice.

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<sup>1</sup> Health Plans for HIPAA Privacy Rule purposes are defined to include the following MassMutual Plans:

- Massachusetts Mutual Flexible Benefits Plan
- MassMutual Employee Welfare Benefits Plan (health option only)
- MassMutual Agents’ Welfare Benefits Plan (health option only)
- Massachusetts Mutual Agents’ Medical Flexible Spending Plan
- Massachusetts Mutual Medical Reimbursement Account Plan
- MassMutual Employee Assistance Program (EAP) (including International SOS (ISOS))
- MassMutual Agent Assistance Program (AAP)
- New: MassMutual Retiree Assistance Program (RAP)
- Massachusetts Mutual Agents’ Long Term Care Plan (LTC) (Plan frozen)

<sup>2</sup> Health Insurance Portability and Accountability Act of 1996

## **How we use and disclose your Protected Health Information (PHI)**

The following describes when we may use and disclose your PHI with and without your authorization. We will explain each category of uses or disclosures and provide examples. Not every use or disclosure in a category will be listed; however, all of the ways in which we are permitted to use and disclose PHI will fall within one of the categories listed in this Notice. You may refer to the HIPAA regulations for a complete listing of permitted uses and disclosures.

### **Use and disclosure with your authorization**

Any uses and disclosures of your PHI other than for the purposes described in this Notice will be made only with your written authorization. You may revoke an authorization that you previously have given by sending a written request to our HIPAA Privacy Contact (refer to the end of this Notice). This revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information the Plans have already used or disclosed, relying on your authorization.

### **Use and disclosure to carry out treatment, payment and health care operations related to the plans**

This section describes how we use and disclose PHI to administer benefits. The Plans and our business associates (see Business Associates section below) may collect, use and disclose PHI about you without your consent, authorization or opportunity to object under the following circumstances:

**Treatment** is the provision, coordination or management of health care and related services by one or more health care providers. For example, the PHI held by our business associates may be disclosed to doctors, dentists, pharmacies, hospitals, and other health care providers who provide services to you.

**Payment** includes but is not limited to actions to make coverage determinations and payment (including billing, pre-authorizations, and claims management). Our business

associates, for example, may use and disclose PHI for pre-authorizations, claims management, billing and coverage determinations based on the terms and provisions of the Plans. The Plans may use or disclose your PHI to pay your claims for benefits.

**Health Care Operations** include but are not limited to: quality assessment and improvement, reviewing competence or qualifications of health care professionals, disease or case management, underwriting, business management, planning and development, and general administrative activities. For example, the Plans and our business associates may use or disclose your PHI for any of the above activities as well as to provide customer service, assist with enrollment or disenrollment activities, and send you information about the Plans.

### **Business associates**

In connection with treatment, payment and health care operations activities, we contract with individuals and entities, called “business associates,” that assist us in administering the Plans and delivering health benefits to Plan participants. For a list of our primary healthcare-related vendors who are our business associates, refer to the end of this Notice.

Our business associates perform various functions on our behalf or provide certain services, including customer service, utilization management, subrogation, and pharmacy benefit management. To perform these functions or to provide other Plan-related services, business associates may receive, create, maintain, use, or disclose PHI but only after we require the business associates to agree in writing to contract terms designed to safeguard your PHI. You should speak with these parties directly if you have questions about PHI maintained by them.

### **Other possible uses and disclosures of PHI**

**To Plan Sponsor:** We may disclose summary health information about you to the Plan Sponsor to decide whether to modify, amend or terminate the Plans. We may also disclose PHI to the Plan Sponsor for Plan administration purposes

only; PHI will not be disclosed or used for purposes of making employment related decisions.

**As Permitted or Required by Law:** We may disclose PHI about you when permitted or required to do so by federal, state or local law. For example, we may disclose your PHI to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws.

**To Avert a Serious Threat to Health or Safety:** Consistent with applicable federal and state laws, we may use and disclose PHI about you when necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. Any disclosure, however, would only be to someone who is reasonably able to prevent the threat.

**Legal Proceedings:** We may disclose your PHI: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal, to the extent such disclosure is expressly authorized; and (3) in response to a subpoena, discovery request or other lawful process once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your PHI in response to a subpoena for such information.

**Where Authorized or Required by Law, For Public Health or Similar Activities:** Additionally, if applicable, we may release your PHI where authorized or required by law and for public health or similar activities, including:

- Releasing PHI to state or local health authorities, as required by law, about particular communicable diseases, injury, birth, death, and for other required public health investigations;
- Releasing PHI to a governmental agency or regulator with health care oversight responsibilities including audits, investigations, inspections, licensure and disciplinary actions, and civil, administrative or criminal investigations;

- Releasing PHI to public health or other appropriate authorities, as required by law, when there is reason to suspect abuse, neglect, or domestic violence;
- Releasing PHI for certain research purposes when such research is approved by an institutional review board with established rules to ensure privacy;
- Releasing PHI to a coroner, medical examiner, or funeral director to assist in identifying a deceased individual or to determine the cause of death;
- Releasing PHI for organ, eye or tissue donation purposes;
- Releasing PHI to worker's compensation agencies if necessary for your worker's compensation benefit determination;
- Releasing PHI to federal officials for intelligence, counterintelligence, and other national security activities authorized by law; and
- Releasing PHI if you are a member of the military as required by the armed services.

## Your individual rights

You have several rights with respect to your PHI, as described below.

**Right to Access your PHI.** You may inspect or obtain a copy of your PHI that is maintained in a "designated record set." A designated record set is a group of records maintained by or for the Plans that is: (1) the medical records and billing records about individuals maintained by or for a covered health care provider; (2) the enrollment, payment, claims adjudication, and case or medical management records systems maintained by or for a health plan; or (3) used, in whole or in part, by or for the Plans to make decisions about individuals. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

Your designated record set maintained by the Plans includes enrollment and disenrollment information such as costs and

contributions, coverage levels, benefit elections, dependent information, and demographic data. Our business associates also maintain PHI about you regarding your enrollment and disenrollment, including such PHI as claims, authorizations and referrals. You should request access to your PHI directly from the appropriate business associate contact listed at the end of this Notice.

In order for you or your personal representative<sup>3</sup> to request access to your PHI, a written request will need to be submitted to the HIPAA Privacy Contact listed at the end of this Notice. Please contact MMBMI for more information concerning this process.

You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot reasonably do so. The requested information will be provided within 30 days of the request if the information is maintained onsite, or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plans are unable to comply with the deadline.

We may impose a fee for requests. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time.

Under certain circumstances, you may be denied access to a portion of your designated record set. If your request is denied, in whole or in part, you may request that the denial be reviewed. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this occurs, we will inform you in our denial that the decision is not reviewable.

**Right to Receive an Accounting of Disclosures.** Upon request, you may obtain an accounting of certain disclosures of your PHI. The accounting provided will not include disclosures made before April 14, 2003<sup>4</sup>, disclosures made for treatment, payment or health care operations, disclosures you have authorized, disclosures made earlier than six years before the date of your request, and certain other disclosures excepted by law.

An accounting will include the date(s) of the disclosure, the person or entity to whom the disclosure was made, a brief description of the information disclosed, and the purpose for the disclosure. You may request an accounting by submitting your request in writing to the appropriate HIPAA Privacy Contact listed at the end of this Notice.

You will not be charged a fee for your first request within any 12-month period. However, we may impose a fee for each subsequent request made within the same 12-month period. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time.

**Right to Request an Amendment to your Records.** If you believe your PHI is incorrect or incomplete, you have the right to ask us to amend your PHI. Your request must be in writing to the appropriate Privacy Contact listed at the end of this Notice, and it must explain why the information should be amended. Your request for an amendment may be denied.

The Plans will act on your request within 60 days of receipt of the request. A single 30-day extension is allowed if the Plans are unable to comply with the deadline. If the request is denied, in whole or in part, we will provide you with a

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<sup>3</sup> Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of authority may take one of the following forms: (1) a notarized power of attorney for health care purposes; or (2) a court order appointing the person as the conservator or guardian of the individual. The Plans have the discretion to deny access to your PHI to a personal representative to protect those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors, including parents.

<sup>4</sup> Accountings provided for the following Plans will not include disclosures made before April 14, 2004:

- MassMutual Employee Assistance Program (EAP) (including International SOS (ISOS))
- MassMutual Agent Assistance Program (AAP)
- Massachusetts Mutual Agents' Long Term Care Plan (LTC)(Plan frozen)
- New: Accountings provided for the MassMutual Retiree Assistance Program (RAP) will not include disclosures made before January 1, 2007.

written denial explaining the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. If your request to amend your PHI is accepted, and the law permits such a change, your record will be adjusted.

**Right to Request a Restriction.** You may request a restriction on the use and disclosure of your PHI for the treatment, payment and health care operations purposes explained in this Notice. While we will consider all requests for restrictions carefully, we are not required to agree to a requested restriction. You may request a restriction by submitting your request in writing to the appropriate HIPAA Privacy Contact listed at the end of this Notice. In addition to other requirements, your request must identify (1) the information for which you want to limit disclosure; and (2) how you want to limit our use and/or disclosure of the information. Please contact MMBMI for more information concerning this process.

**Right to Request Confidential Communications.** If you believe that a disclosure of all or part of your PHI may endanger you, you have the right to request to receive communications of your PHI from us by alternative means of communication or at alternate locations. For example, you may ask that we provide you with this information at your work address.

You must make your request in writing, and you must state that the information could endanger you if it is not communicated in confidence by the alternative means or directed to the alternate location you indicate. In order to send your PHI to an alternate location, you will need to complete an Authorization Form (available on My HR, My Benefits and BenefitsChoice). Please contact MMBMI for more information concerning this process.

**Right to Receive Paper Copy of this Notice.** You may request a paper copy of our Notice at any time by contacting MMBMI toll-free at 1-866-MMBMI-4-U (1-866-662-6448) weekdays between 8 a.m. and 5 p.m., ET. This Notice is also available in electronic form on My HR, MMInfo, My Benefits, FieldNet and BenefitsChoice.

### Contact Information

If you want more information about the Plans' privacy policies or practices or have questions or concerns, you may contact MMBMI toll-free at 1-866-MMBMI-4-U (1-866-662-6448) weekdays between 8 a.m. and 5 p.m., ET.

You may direct written requests, questions, or complaints to MMBMI's HIPAA Privacy Contact:

Chief Compliance Officer  
MassMutual Benefits Management, Inc., F205  
1295 State Street  
Springfield, MA 01111

If you believe your privacy rights have been violated, you may file a complaint with us by submitting a written complaint to MMBMI's HIPAA Privacy Contact at the above address. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services: Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. We support your right to protect the privacy of your PHI.

We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

# Vendor Privacy Contacts

## Aetna

*(Medical, Aetna Behavioral Health, Employee, Agent and Retiree Assistance Programs, Long-term Care)*

Call the number on the back of your ID card

Aetna's Legal Support Services Department  
151 Farmington Avenue, W101  
Hartford, CT 06456-9998  
Attn: Manager

## Blue Cross Blue Shield

*(Medical: Advantage Blue)*

1-800-486-1136

Blue Cross Blue Shield  
P.O. Box 9131  
North Quincy, MA 02171-9131

## International SOS Assistance, Inc.

1-215-942-8000

HIPAA Privacy Contact  
3600 Horizon Boulevard  
Suite 300  
Trevose, PA 10953-6956

## CIGNA

*(Medical, Dental, Prescription Drugs)*

1-800-548-3980

Privacy Office  
CIGNA HealthCare  
PO Box 5400  
Scranton, PA 18503

## ConnectiCare

*(Medical)*

1-800-251-7722

Maria Stiefel  
Legal Department  
ConnectiCare, Inc.  
174 Scott Swamp Road  
Farmington, CT 06032

## Health New England

*(Medical)*

1-413-787-4000

Renée Wroth  
Attorney/Compliance Officer  
Health New England  
One Monarch Place  
Springfield, MA 01144

The Plan may enter into other business associate agreements in addition to those listed above. For information on other business associates or on whether a vendor is a business associate, contact MMBMI at the address above.

A separate HIPAA Privacy Notice, including contact information, is sent to Plan participants who are enrolled in the following options: Aetna Dental, BlueCross BlueShield of Rochester, Kaiser Permanente, Oxford and Aetna Long Term Care.

